

EXIT, VOICE AND THE DECAY OF THE  
WELFARE STATE PROVISION OF  
HOSPITAL CARE

---

A thesis  
submitted in partial fulfilment  
of the requirements for the Degree  
of  
Master of Arts in Political Science  
in the  
University of Canterbury

by  
G.M. Fougere

---

University of Canterbury

1974

72.5  
765  
974.

## CONTENTS

CHAPTER	PAGE
ABSTRACT	1
ACKNOWLEDGEMENTS .....	2
INTRODUCTION .....	3
Notes .....	6
1. THE ARGUMENT OUTLINED .....	7
Definition of concepts: exit and voice .....	8
How exit fails to signal the need for remedy .....	11
How exit makes things go from bad to worse .....	17
How voice makes things better ...	19
Which option will be used .....	24
Loyalty and exit .....	29
Will any voice occur .....	33
Chapter summary .....	35
Notes .....	38
2. METHODS OF DATA COLLECTION .....	46
The surveys .....	47
The survey of medical care consumers .....	48
Choice of population .....	48
Getting permission to draw the sample .....	50
How many people to sample .....	51
Drawing the sample .....	51
The interview schedule .....	53

The selection and training of interviewers .....	55
The problem of children .....	56
Pretesting .....	57
Conducting the interviews .....	57
Coding the interviews .....	60
Survey of parliamentarians and hospital board members .....	61
Content analysis of letters to the editor .....	62
Use of official statistics .....	63
Other sources of information .....	64
An evaluation of the research design .....	64
Notes .....	66
3. THE INCIDENCE OF EXIT AND VOICE .....	69
Why no voice? .....	70
Evidence from the medical insurance survey .....	71
Evidence from the waiting list ... survey .....	75
The availability and cost/effectiveness of voice and exit: the cost/effectiveness of voice .....	76
The availability and relative cost/effectiveness of voice and exit: the monetary costs of exit .	84

The availability and relative cost/effectiveness of voice and exit: loyalty and exit .....	87
The cost/effectiveness of exit and voice compared .....	90
The waiting list as a choice situation: exit or voice? .....	91
The waiting list as a choice situation: stayers and voice .....	97
The overall incidence of exit .....	106
The future incidence of exit .....	112
The overall incidence of voice: evidence from the survey .....	114
The incidence of voice: evidence from voice collection points .....	116
The future of voice .....	119
The expected exception: where exit is not available to anyone .....	120
Chapter summary .....	121
Notes .....	122
4. CONSEQUENCES OF EXIT AND VOICE .....	125
Exit and the repair of public sector lapses .....	126
Voice and the repair of public sector lapses .....	142
Waiting lists and repair .....	148



The differential response of governments to voice .....	149
Summary: the chances for repair in the present circumstances .....	152
How exit drains resources from the public sector: finance and medical personnel .....	153
Exit and the demand for public sector services .....	162
How exit drains resources from the public sector: energy and concern.	167
Putting it together: the consequence of exit and voice compared .....	176
Chapter summary .....	177
Notes .....	179
5. AVOIDING THE INEVITABLE .....	193
The consequences of the continuing dominance of exit .....	194
Will exit continue? .....	197
Will anyone care? .....	212
What kind of solution? .....	218
Why monopoly .....	220
What kind of monopoly? .....	221
How can monopoly be made responsive? .....	227
Conclusion .....	229

## CHAPTER

PAGE

Notes .....	231
APPENDIX 1: HOW THE SAMPLES WERE DRAWN .....	237
APPENDIX 2: INTERVIEW SCHEDULES, INSTRUCTIONS TO INTERVIEWERS AND LETTER SENT TO THOSE INTERVIEWED .....	245
APPENDIX 3: LETTERS SENT TO PARLIAMENTARIANS AND HOSPITAL BOARD MEMBERS .....	269
APPENDIX 4: WHY PEOPLE TAKE OUT MEDICAL INSURANCE: THE SOUTHERN CROSS EVIDENCE CONSIDERED .....	273
LIST OF REFERENCES CITED .....	277

# LIST OF FIGURES

FIGURE	PAGE
1. Diffusion curves for medical insurance.	112

## LIST OF TABLES

TABLE	PAGE
1. What happened to each respondent sampled	58
2. Comparison between complete waiting list sample and non-interviewed in waiting list sample .....	59
3. Comparison of complete medical insurance sample, interviewed and non-interviewed, in medical insurance sample .....	60
4. Responses to the questions, "what do you see as the advantages to you of having medical insurance?" .....	72
5. Importance of three given reasons in the decision to take out medical insurance .	73
6. What kind of hospital provides the better care? (medical insurance sample).	74
7. How those on the waiting list feel about having to wait and the standard of public sector care .....	76
8. Which kind of hospital provides better care? (waiting list sample) .....	76
9. Is there anything that can be done to increase the supply or improve the standard of public sector care? .....	77
10. Reasons why voice strategies do not work	79
11. Analysis of voice responses .....	80
12. Voice responses and collective benefits	81
13. Evaluation of suggested voice strategies	83

TABLE	PAGE
14. Willingness to pay higher premiums .....	85
15. Choice of hospital if uninsured .....	85
16. Age distribution of medical insurance respondents .....	86
17. Income distribution of medical insurance respondents .....	87
18. Reasons given for not exiting by those in the waiting list sample reporting themselves dissatisfied with public sector care .....	89
19. Income distribution: waiting list and medical insurance respondents compared .	93
29. Years of education: waiting list and medical insurance respondents compared .	94
21. Occupational prestige: waiting list and medical insurance respondents compared .	94
22. Distribution of exit choice in waiting list sample .....	95
23. Distribution of leavers by kind .....	95
24. The incidence of voice among stayers ...	96
25. The incidence of voice among leavers ...	97
26. Responses of leavers and stayers to satisfaction with supply question, compared .....	98
27. Responses of leavers and stayers to satisfaction with standard question, compared .....	99

## TABLE

## PAGE

28.	Mean years of education of dissatisfied stayers, leavers and the medically insured .....	100
29.	Mean income of dissatisfied stayers, leavers and the medically insured .....	100
30.	Occupational prestige of dissatisfied stayers, leavers and the medically insured .....	100
31.	Age distribution of leavers, dissatisfied stayers and the medically insured .....	102
32.	Mean ages of leavers, dissatisfied stayers and the medically insured compared .....	103
33.	Political energy of dissatisfied stayers leavers and medically insured compared .	104
34.	Mean number of voluntary associations belonged to by association members among dissatisfied stayers, leavers and the medically insured .....	105
35.	Degree of activity of political party members among dissatisfied stayers, leavers and the medically insured .....	105
36.	Opinion leadership: how likely is respondent to be asked his opinion on political and social issues compared with his circle of friends? .....	106

## TABLE

## PAGE

37.	Private hospital claims: post office and public service welfare societies ...	108
38.	Surgical admissions to private hospitals by health district .....	111
39.	The incidence of voice among medical insurance respondents .....	115
40.	Number of complaints received by hospital board members .....	116
41.	Topics of letters to the editor dealing with hospital care .....	118
42.	Average day stay for varicose veins: Auckland public and private hospitals 1955-1972 .....	128
43.	Average day stay for abdominal hernia: Auckland public and private hospitals 1955-1972 .....	129
44.	Attitudes of hospital board members to exit .....	130
45.	Rate of exit and the provision of public hospital beds .....	133
46.	Money paid out each year under government loan schemes: 1952-1973 .....	136
47.	Allocation of loan money by health district 1952-1973 .....	138
48.	Daily patient benefit paid to private hospitals 1939-1973 .....	139

TABLE	PAGE
49. Total amounts paid in patients benefits 1963-1973 .....	139
50. Mean number of hospital beds in exit and no exit areas .....	147
51. Specialists employed in hospital service November 1973 only .....	158
52. No. of full-time equivalents worked in waiting list specialties: 1968 and 1973	160



# ABSTRACT.

The consequences for public sector medical care of the introduction of medical insurance into New Zealand are traced. The analysis is based on a simple choice model describing consumer decisions and their consequences; it is elaborated by data drawn from government records, survey interviews with insured and uninsured groups and mail questionnaire responses from politicians. It is argued that the ultimate consequence of the introduction of medical insurance is the destruction of welfare state arrangements for the provision of medical care. The thesis concludes with the formulation of a proposal likely to prevent this.

## ACKNOWLEDGEMENTS.

Every writer incurs debts which can never be acknowledged adequately. Mine are to John Orbell and Barbara Craig. John Orbell first introduced me to the concepts of exit and voice and encouraged me in my application of them to the problem of medical care. As well, the numerous discussions we have had together about what constitutes good and bad social science, important and unimportant questions, forms the intellectual bed-rock of which this thesis is an outcropping. I will not attempt to describe my debt to Barbara Craig. She and John Orbell know its extent.

I also owe thanks to Mr J.O. Mackie and Dr G.C. Salmond of the Department of Health, both of whom gave a great deal of help and encouragement to me throughout the project; to Professor W.K. Jackson who never despaired of something worthwhile emerging and was at all times kind and encouraging; and to Mr Peter Smith, general manager of the Southern Cross Medical Care Society, for his co-operation in a project about which no promises were made.

Finally I owe thanks to all those people who allowed themselves to be interviewed, or kindly replied to my letters, as well as those who helped with the interviewing.

## INTRODUCTION.

These days there is widespread belief that the provision of public sector hospital care is inadequate. Most New Zealanders know someone who is or has been on a hospital waiting list or are themselves in such a position; in March 1973 hospital waiting lists totalled 33,989.<sup>1</sup> Most New Zealanders have heard stories about children who can't hear properly at school or adults who "just deteriorated" waiting for surgery.

The establishment and rapid growth of medical insurance organisations has been the single most important consequence of belief in the inadequacy of public sector care. The Southern Cross Medical Care Society has grown from about 1,000 to more than 30,000 members in less than fifteen years; each year its membership has roughly doubled. Other similar societies also report impressive growth, although their total membership is much lower.<sup>2</sup>

In this thesis I attempt to trace the consequences for public sector medical care of the introduction of medical insurance into New Zealand. The matter was considered at some length by the Royal Commission of Inquiry into Social Security in New Zealand. In the absence of relevant data the Commission could only speculate about what might be going on; the results were sufficiently disquieting for it to conclude, "We think that this whole question needs examination in the context of the optimum delivery of health services".<sup>3</sup> This thesis is first of all, a systematic attempt at such an explanation.

My analysis suggests that the ultimate consequences

of the introduction of medical insurance is the destruction of the welfare state provision of medical care and its replacement by market arrangements. On the basis of the available evidence I believe this to be an outcome desired by few New Zealanders. Thus the thesis also involves a proposal for a single, simple policy innovation that promises good quality, "no waiting" hospital care distributed through the public sector.

I begin the analysis by developing a choice model based on the work of Albert O. Hirschman.<sup>4</sup> The model is used to generate a number of empirically testable propositions about the strategies likely to be followed by those dissatisfied with public sector care, the likely actions of other interested actors, and the overall consequences for the provision of public sector care.

In the second chapter I outline the data collection methods I used and evaluate the research design as a whole. In the third and fourth chapters I bring the propositions developed from my argument and the real world together. My basic conclusion is that there is a nice "fit" between what appears to be going on in the real world and my argument. Finally I assess the likely consequences of the trends I have identified and, on the basis of the preceding analysis, suggest a solution likely to please most New Zealanders.

The thesis could have been written either as an exercise in the application and testing of a social science theory, or as an attempt to use social science theory to make sense of a concrete problem. Although the two approaches invariably overlap, I have chosen to lay emphasis

on the second. Thus, the third function of this thesis is to provide an exemplar of the kind of work that might be done by a Centre for the Study of New Zealand Society and hopefully, by demonstration, an argument in support of its establishment.<sup>5</sup>

The chief consequences of this approach appear in my use of the available literature. Because the research problem is drawn from my own concern about developments in New Zealand society, rather than from a "problem area" in social science theory, a number of literatures in several social science disciplines bear on the argument. In my use of this literature I have drawn only on those ideas that seemed to contribute directly to an understanding of the concrete problem at hand; I have deliberately refrained from the cut, thrust and "brilliant" synthesis of theoretical gamesmanship.

It remains to clarify my own position. I care a great deal whether medical care is allocated on the basis of need or on the basis of ability to pay; I would not like to live in a society where access to medical care, and thus the enjoyment of life and sometimes life itself, is once again determined by the size of a sick person's purse. The research question arose from my concern that the legislation providing for the welfare state provision of medical care was being repealed de facto, by market encroachment. What follows represents my attempt to establish as accurately as possible the extent to which my concern was justified and, as well I could, suggest a workable remedy for it.

## NOTES.

<sup>1</sup>The Press September 13, 1973.

<sup>2</sup>For details see Chapter 3.

<sup>3</sup>The Royal Commission on Social Security in New Zealand, Social Security in New Zealand (Wellington: Government Printer, 1972) p.397.

<sup>4</sup>Albert O. Hirschman, Exit, Voice and Loyalty: Responses to Decline in Firms, Organisations and States (Cambridge, Mass: Harvard University Press, 1970).

<sup>5</sup>Geoffrey M. Fougere and John M. Orbell, "A Proposal to Establish a Centre for the Study of New Zealand Society" (Forthcoming, Australia and New Zealand Journal of Sociology, October 1974).

CHAPTER 1: THE ARGUMENT OUTLINED

People dissatisfied with the quality of public sector hospital services have three options open to them: they can transfer their custom from the public to the private sector; they can act to improve the quality of public sector services; or they can simply do nothing.<sup>1</sup> The introduction of medical insurance schemes into New Zealand has changed the costs of the first option relative to the other two. By spreading the costs over time and between people, medical insurance makes it possible for many more people than previously to afford private sector care. My major concern is to trace the consequences of this change.

#### DEFINITION OF CONCEPTS: EXIT AND VOICE.

Albert Hirschman has outlined a general theory of organisational decay based on the use of the first two options.<sup>2</sup> He argues that consumers who are dissatisfied with the performance of an organisation they patronise can either 'exit' or 'voice'. Exit involves leaving the organisation or switching to a competing product.<sup>3</sup>

Voice is:

... any attempt at all to change, rather than to escape from, an objectionable state of affairs, whether through individual or collective petition to the management directly in charge, through appeal to a higher authority with the intention of forcing a change in management, or through various types of actions and protests, including those that are meant to mobilise public opinion.<sup>4</sup>

In Hirschman's terms, the person who opts out of the public sector in favour of the private, exits. A person who exits gives up none of his rights to make use of public



sector services; nor can he stop paying taxes to support the public sector. At the same time, exit is only possible where the public and private sectors offer competing medical services: I can choose between a public or private hospital to have my tonsils removed, but only public hospitals have the facilities to transplant kidneys. Thus, exit involves the decision to use private, rather than public sector, facilities in specific circumstances; it is not necessary that a person quit the public sector in its entirety. In this sense exit from the public sector is always partial.

Establishing the actions necessary for exit poses a second problem of definition: do I have to actually make use of private sector facilities (for example by having my tonsils out) to be said to have exited, or is it sufficient that I insure against the possibility? Taking out medical insurance involves my decision to make use of private sector services in future; properly speaking paying insurance premiums constitutes pre-payment of private sector benefits I hope to enjoy if I should fall ill.<sup>5</sup> Thus, people exit, either when they take out medical insurance, or (not being insured) they make use of private sector services.

As a first approximation, the person who voices is one who would rather, "fight than switch" through the use of any strategy calculated to improve public sector service. Two quite different categories of motives may lie behind the use of voice. My voice may be aimed at winning benefits

that accrue only to me (selective benefits): for example I write to the hospital board in an effort to get my name moved up the waiting list. Alternatively my voice may be aimed at winning benefits that accrue not only to myself but to everyone else (collective benefits): for example I again write to the hospital board, this time in an effort to improve hospital performance so that everyone waits less time for service.<sup>6</sup>

But the results of my use of voice may be quite different to those I intend. The efforts of myself and others to get our names moved up the waiting list may alert those responsible to the political fact that there is widespread dissatisfaction with waiting times. Thus, my efforts to improve my welfare may result in steps being taken to improve public sector performance; a benefit that accrues to everyone.<sup>7</sup> Alternatively, my pursuit of a collective benefit may result in attempts to "buy me off" with selective benefits: for example, to save trouble, the hospital board arranges to have me immediately admitted to hospital.<sup>8</sup> Here my main concern is with voice that results, or may result, in steps being taken to improve overall public sector performance (i.e. a collective benefit), regardless of its motivation.<sup>9</sup>

Hirschman's theory focuses on the consequences for the organisation of clients' decisions to exit or voice: will the actions taken by those dissatisfied lead to an improvement or deterioration in the organisation's performance? This is my main concern in regard to public sector hospital care. Is exit or voice more likely to

improve public sector performance? I will argue that voice, rather than exit, is most likely to bring about improvement in the quality of public sector service. Exit, unlike voice, fails to focus the attention of those responsible on public sector deficiencies, while, at the same time, it acts to deplete the public sector of those resources most necessary for its improvement.

#### HOW EXIT FAILS TO SIGNAL THE NEED FOR REMEDY.

That the use of exit may work to make things worse, rather than better, contradicts conventional economic wisdom. Everyone knows that competition keeps organisations on their toes. In fact, one response to the failure of public sector organisations to deliver the goods in the United States and elsewhere, has been the advocacy of institutional reforms to introduce competition into the provision of public services. Milton Friedman, for example, has argued that competition between schools may improve the performance of school systems.<sup>10</sup> The rationale underlying his and other similar arguments is as follows:

The classic antidote to monopoly is competition. By introducing alternative sources of supply, competition expands the choice available to consumers. Moreover, these alternative sources are likely to use different methods and approaches, or even to develop wholly new products, thus greater variety makes expanded choice really meaningful. Since consumers can shift their trade from suppliers who do not please them, suppliers have a strong incentive to provide what the consumers want. This attitude also means competitors regard innovations positively as potential means of winning more business... In contrast monopolists usually view innovations negatively, as a bother designed to upset established

routines for no good reason. Clearly if greater competition causes these results in general, it might produce some tremendous improvements in big city school systems.<sup>11</sup>

When consumer decisions determine the allocation of resources among competing companies, those who control the companies are likely to pay close attention to evidence of change in consumer preferences. Losing customers can mean the loss of managerial positions and sometimes the extinction of the company. Thus managers are alert to any indication of customer exit, and, where it occurs, will have a maximum incentive to improve the organisation's product to stem further losses and perhaps win back old (and some new) customers.

But the case of public sector medical care is not analogous.<sup>12</sup> Entering the private sector requires ready cash, thus guaranteeing that no matter how unsatisfactory the performance of the public sector it will at least retain those consumers who are too poor to exit.<sup>13</sup> At the same time, exit by those who can afford it, may fail to alert those responsible to deficiencies in public sector services. Because the public sector draws its funds from Treasury rather than directly from its clients, even quite large amounts of exit are unlikely to pose a direct threat to the system's continuance. Not surprisingly the public sector does not monitor its customer gain or loss and is not curious about the reasons for shifts in consumer preference.<sup>14</sup> Even when exit is seen as a signal that something is wrong, the insulation of the allocation of

resources from the decisions of consumers, means that no financial incentive to remedy deterioration is created. In fact the self interest (financial and otherwise) of many of the actors involved may lead them to take actions aimed at encouraging rather than stemming exit.

The many doctors who have private, in addition to public hospital practices, are in such a position. Because the remuneration for private sector work is considerably higher than for public, and because they enjoy their public sector salaries regardless of how many patients they treat, the more private sector patients such doctors see, the higher their income.<sup>15</sup> But the flow of private sector patients depends in large part on continuing deficiencies in the public sector. Thus the harder doctors work in the public sector, the fewer patients exit and the lower their incomes become.<sup>16</sup>

The members of hospital boards may also welcome exit. The more exit, the happier their part-time medical staff will be; thus boards anxious to cement good staff relations may be pleased by exit. More distantly, the growth of active consumer dissatisfaction with public sector services may threaten the re-election chances of those apparently responsible. The existence of the exit option allows discontented consumers to avoid "poor" service, helping to "keep things quiet" and making the re-election of board members more likely.<sup>17</sup>

Regardless of their ideological commitment governments may also seek to make exit more readily available (or at least not repeal the "exit" legislation of their

predecessors). The Medical Association of New Zealand (M.A.N.Z.) is a powerful and successful interest group which has stubbornly opposed any attempt to erode the private sector. No government will lightly cross it.

But even if M.A.N.Z. did not exist governments still have good reason to make exit more readily available. As voting surveys reveal, citizens wish governments to provide them with as many goods and services as possible but at the same time are anxious that they should personally bear as few as possible of the costs involved: for example, I want more government money spent on schools and I also want to pay less taxes. Anthony Downs argues that governments that wish to be re-elected in such circumstances will seek to "carry out those acts of spending which gain the most votes by means of those acts of financing which lose the fewest votes".<sup>18</sup>

Governments faced with evidence of citizen dissatisfaction with public sector medical services have several options open to them. They may choose to do nothing, estimating either that dissatisfaction is not widespread enough to appreciably affect their re-election chances, or that more votes can be won by spending the required money in other areas.

Alternatively governments can expend resources to upgrade the entire public sector to the satisfaction of those who complain. Finally governments may seek to selectively provide better hospital services for those who are dissatisfied; either by subsidising the costs of obtaining private sector care, or in areas where such care is not available, upgrading public sector facilities.

Expending resources to upgrade public sector services on a nation-wide basis lessens the dissatisfaction of those who complain but obviously does not make those who are already perfectly satisfied any happier. Such people may in fact resent extra spending on medical services if this makes less money available to upgrade other services with which they are dissatisfied. Thus only when very large numbers of citizens are actively dissatisfied with the provision of public sector services, all at the same time, are governments likely to undertake major new expenditures to upgrade them. Such occasions are infrequent.<sup>19</sup>

More usually, governments face situations in which some small percentage of the population is dissatisfied with the provision of hospital services at any one time (although, over time, a majority of the population may fit into the dissatisfied category). In these circumstances, subsidising the costs of obtaining private sector care allows governments to reap the greatest amount of satisfaction for the smallest expenditure of their resources in each time period. Governments only subsidise the costs of private sector care, while they would pay in full for the provision of similar care in the public sector.<sup>20</sup> Better still, the subsidy is a selective one, going only to those people who are dissatisfied with public sector services (although even when exit is heavily subsidised, it is unlikely that all of those dissatisfied will be able to leave). Finding a "cheap" solution to discontent frees scarce resources for the pursuit of other government objectives, whether these

be the advancement of class interests or the personal enrichment of politicians.

Thus governments, anxious to avoid the electoral consequences of dissatisfaction with public sector medical services, will be unlikely to restrict exit and may seek to make the option more widely available. (In areas where no private sector exists, and none can be created by government subsidy, this strategy is of course unavailable: then governments have to upgrade public sector services in the locality).

#### SUMMARY.

I have suggested that exit has different consequences according to whether it occurs in the private or public sector (assuming that the private sector operates in competitive market conditions). This is because:

- a. In the public sector (unlike the private) attention is not routinely paid to any loss or gain of customers; even large scale exit may pass unnoticed. Thus exit will often fail to alert those responsible for public sector performance of consumer dissatisfaction.
- b. Even if alerted to dissatisfaction, the existing incentives encourage efforts to make exit more readily available rather than efforts to stem exit by remedying public sector defects.

Thus exit does not precipitate efforts to improve public sector performance.



## HOW EXIT MAKES THINGS GO FROM BAD TO WORSE.

But exit is an effective means of worsening public sector performance. By expanding the private sector, it drains the public sector of its resources of capital, personnel, and energy and concern.

The state heavily subsidises private sector activities. It provides low interest loans for the creation of new private hospitals and the expansion and renovation of existing ones.<sup>21</sup> It also directly subsidises use of the private sector through the payment of a patient benefit and through a tax subsidy on the payment of medical insurance premiums.<sup>22</sup> As well further "invisible" state subsidies occur: drugs and laboratory services are paid for by the state, radiological services are state subsidised and so on. The more people make use of the private sector, the more the state pays out in subsidies; thus exit has the effect of diverting financial resources from the public to the private sector.<sup>23</sup>

The public and private sectors also compete to secure the services of doctors.<sup>24</sup> The pool of doctor services on which both sectors draw is characterised by an important fact: the total size of the pool is too small to satisfy present demand; waiting lists occur, in the first instance, because there is a shortage of doctor services.<sup>25</sup> Because demand for medical services tends to rise with increases in supply, and because the long training time of doctors means that there is always a delay between increasing

demand and increasing numbers of doctors, the situation is unlikely to change in the next few years.<sup>26</sup> Thus the competition for doctor services between the public and private sectors will often be zero sum. Because the pool of services is "too small", every doctor joining the private sector will mean one less doctor for the public sector.

Private sector practice is inherently more attractive than public for many doctors. Specialists who can establish themselves in the private sector are likely to earn much more than their counterparts in the public sector.<sup>27</sup> Private practice also offers escape from the demands of bureaucratic organisation. Consequently, if sufficient demand exists, many doctors will prefer private to public sector practice.

Demand for private sector services depends on consumer exit from the public sector: the greater the number of people exiting the greater the demand for private sector services and the more likely doctors are to choose private rather than public sector practice. Thus by making the choice of private sector practice more likely, exit works to drain the public sector of its resources of skilled personnel.

Exit also works to drain the public sector of its resources of energy and concern. Hirschman points out that,

... those customers who care most about the quality of the product and who, therefore, are those who would be the most active, reliable and creative agents of voice are for that very reason also those who are apparently likely to exit first in the case of deterioration.<sup>28</sup>

In the present context, those people who care most about securing satisfactory medical care for themselves and their families are those who have the greatest incentive to do something, either exit or voice, in the face of poor public sector performance. Their choice of exit means that the public sector loses the energy and concern of those customers who, if they had stayed, would have had the greatest incentive to seek ways to improve public sector services, a situation, "which paralyses voice by depriving it of its principal agents".<sup>29</sup>

#### SUMMARY

I have argued that exit is unlikely to stimulate efforts to improve public sector performance. At the same time exit works to drain the public sector of those resources on which its recovery depends. Thus exit, rather than leading to the improvement of the public sector, makes it likely that public sector performance will worsen.

#### HOW VOICE MAKES THINGS BETTER

Voice will have the opposite effect, working to remedy rather than worsen public sector deficiencies. The agents of voice, as of exit, are those consumers who are actively dissatisfied with public sector services. However, they choose to resolve their dissatisfaction, not by leaving the public sector, but by seeking to bring about its

improvement.<sup>30</sup> Thus unlike exit, voice does not drain the public sector of its resources.

Voice also works to alert those responsible to public sector deficiencies and often provides powerful incentives for remedial action. The immediate responsibility for the provision of satisfactory hospital services in an area lies with local hospital boards. There is some evidence that the elected members of the boards pay attention to public demands.<sup>31</sup> Certainly, inasmuch as board members are anxious to be re-elected and their re-election depends on satisfying voters, they have every incentive to pay close attention to community spokesmen.

But real responsibility for the satisfactory provision of hospital services and medical services in general, lies with the central government, rather than local bodies. The amount of money that local boards have to spend on hospital services is decided by central government, and local boards have little discretion in the allocation of the finances they do receive. The ultimate power to decide how many nurses will be trained, how many doctors employed, at what salaries and in what specialties, what new building will be done and so on, is exercised in Wellington.<sup>32</sup> The new Hospitals Amendment Bill making Board members personally liable for spending "without due regard" of the provisions of the Hospitals Act limits still further the discretion of local boards.<sup>33</sup>

As well, other kinds of government decisions determine the kind and amount of demand that will exist for hospital

services, and thus affect public hospital performance. At the most basic level, government decisions affecting the distribution of wealth within a society vitally affect the incidence and distribution of sickness. Public Health measures such as the financing of sewage treatment plants, the enforcement of building and industrial safety and health codes, the use of mass X-rays and vaccinations and so on, all vitally affect demand for hospital services. Finally, within the medical care system itself government decisions about the number and distribution of doctors (as for example are involved in the decision to build a new medical school) help to determine how many sick people end up in hospitals.<sup>34</sup> Thus the decisions most crucially affecting hospital performance are those made by government.

There is every reason to believe that members of parliament will pay careful attention to voice. Politicians who make decisions without calculating the likely electoral consequences soon lose office, as do politicians who wrongly calculate the electoral consequences of their decisions. And positively, politicians who early detect the emergence of new public concerns can build new power bases or restore themselves to old ones.

Not surprisingly members of parliament spend a great deal of time looking for and listening to, voice. They have regular contact with organised public opinion in the form of pressure groups at both the local and national levels and even when parliament is in session, they spend

a good deal of time in their own electorates listening to the grievances of their constituents in formal office sessions. As well through party canvassing and their own regular attendance at local functions they actively seek out public concerns. Thus voice, unlike exit, is likely to quickly alert politicians to the existence of dissatisfaction.

Voice also serves as a powerful prompt to politicians to seek out and implement remedies for deterioration. Because it represents active discontent with government policies, voice threatens to drain off the electoral support for government. Further, voice is usually highly contagious. Those people who are dissatisfied communicate their concern to others and often try to recruit them to the cause.<sup>35</sup> In New Zealand, where quite small changes in public opinion make important differences to electoral outcomes, governments that wish to be re-elected will seek to still voice by remedying its cause.<sup>36</sup> Thus voice both alerts those responsible to the fact that something is wrong and provides incentives for them to implement remedies.<sup>37</sup>

The recent efforts of people in rural areas to secure better medical care for themselves is an example of the successful use of voice. Changes in the distribution of population and the practice of medicine, have made the practice of medicine in rural areas increasingly unattractive to doctors. At the same time, New Zealand's overall shortage of general practitioners has made entry into

successful city practice easier and more lucrative.<sup>38</sup> The result of these changes became apparent in the early 1960's as country areas began to lose their local doctors.<sup>39</sup> As a consequence a number of representations to government were made by Federated Farmers and rural local bodies arguing the need for urgent government action to encourage doctors to enter and remain in practice in rural area. These efforts resulted in a number of government measures climaxing in the government's decision to introduce a Rural Practice Bonus (as of October 1, 1969).

The latest information on the distribution of doctors within New Zealand suggests that the situation has improved considerably since then. This improvement was "partly due to population changes, but the rural practice... incentives played an important part".<sup>40</sup> It is clear that the use of voice can both alert government to the fact that something is wrong in the provision of medical care and encourage government efforts to find remedies.

The final option open to dissatisfied consumers is to simply do nothing. Passivity does not drain resources from the public sector and thus, unlike exit, does not actively worsen public sector performance. But neither will it alert those responsible of consumer dissatisfaction, nor provide them with an incentive to implement remedies. Observed from outside, passive dissatisfaction is indistinguishable from contentment and will usually be understood as such.

## SUMMARY

Thus of the three options discussed, only voice both fails to drain resources from the public sector and works to encourage efforts to remedy public sector deficiencies. I conclude that it is voice, not exit or passivity, that is likely to bring about an improvement in public sector performance.

## WHICH OPTION WILL BE USED?

Clearly it is now important to know the circumstances in which dissatisfied consumers choose one option rather than another. Choice is simplified in situations where exit or voice is unavailable. For example, in rural areas without a local doctor, dissatisfied consumers cannot purchase the services of a locally available general practitioner substitute, no matter how much they might like to. Thus exit is unavailable: consumers anxious to improve the local provision of medical care have only voice open to them.

But for consumers dissatisfied with public sector hospital services, both exit and voice can be used to remedy dissatisfaction in areas with alternative private sector services. By switching to the private sector, consumers can avoid the long waiting times associated with the public sector and ensure themselves of more "personal" service, all without giving up any of their rights to use the public sector. Alternatively, consumers can seek to remedy their



dissatisfaction by working to improve public sector performance. In these circumstances how will consumers choose whether to voice, exit, or remain passive?

I begin by making the simple assumption that a dissatisfied person chooses between options by weighing the likely costs of each option against the benefits that he expects will accrue from it. He will choose that option which seems to him to offer the greatest personal benefit at the least personal cost.<sup>41</sup>

For the moment I assume further that the act of exiting, like passivity, costs the consumer nothing, involving only the simple decision to leave the public sector. But this switch, unlike passivity, which gains the consumer nothing, guarantees the immediate enjoyment of the private sector benefits outlined above. Clearly exit will be chosen over passivity in such a situation. But what about voice; will voice occur at all in these circumstances? To know it is necessary to estimate the costs and benefits of voice relative to those of exit.

Even a small amount of voice may often cost the dissatisfied consumer a considerable investment of time, energy and perhaps money. First, for voice to have any chance of working at all, the consumer will need to collect some information on where and how best to use it. For example, does responsibility lie with hospital boards, the government or the medical profession; how is it possible to influence those responsible and so on? Second, the consumer must expend time and energy in the act of voicing

itself. While sometimes energy expenditure may be minimal, as in the case of voting, or complaining to a doctor, more effective forms of voice are likely to require considerable effort.

Those who voice may also suffer social costs for their activity. For example, among many groups of people the use of voice strategies such as demonstrating, striking and even writing letters to a newspaper may carry considerable social stigma. Simple personal embarrassment may constitute another formidable voice cost. One articulate, wealthy and well educated respondent in the Medical Insurance sample argued that "[he] would have to be a pretty green Joe Soap to go along to [his] local M.P. and say, "Look here, our health system's crashing down around our ears"". More generally many respondents in both samples were reluctant to answer some of the survey questions because they were not "complaining types" of people.

Voice costs accruing to individuals can be drastically reduced by the existence or creation of organisations that allow members to share these costs. Often organisation allows the delegation of the actual task of voicing to full time (paid and unpaid) personnel. At the same time the greater ability of organisations to explore and utilise channels of influence and accumulate information means that the total "unit cost" of voice is likely to be considerably lower than if each member relies on his own efforts.

For example, rural people wishing to improve their local general practitioner service, were able to exercise

voice through the Federated Farmers, a body whose continued existence depends on its ability to effectively articulate the concerns of its rural members.<sup>42</sup> Working through an organisation, they gained immediate access to established community contacts in all rural areas, allowing them both to collect information about other areas and quickly disseminate their concern about their own. Federated Farmers also provided research personnel, opened up an institutionalised channel to government and allowed the utilisation of the organisation's accumulated influence and skill in bringing pressure to bear for remedy.

No comparable organisation exists to represent the concerns of the consumer of public sector medical care. Of established New Zealand interest groups only the Public Service Association (to my knowledge) has expressed concern at public sector performance.<sup>43</sup> Paradoxically, the chances of voice costs being reduced either by the creation of a new organisation or the utilisation of an established one, will vary, in part, according to the number of dissatisfied consumers who decide to stick with the public sector and voice. But the high cost of voice in the absence of organisation increases the attractiveness of the exit option. The extensive use of exit reduces the chances of successful organisation. Thus the absence of organisation constitutes a major structural restraint on the appearance of voice: where no organisation exists, and exit is easy, the costs of voice are likely to remain high.

In addition to their expenditure of time and energy,

dissatisfied consumers who choose voice will also bear considerable opportunity costs. By staying with the public sector they forgo the immediate and certain enjoyment of the benefits that exit provides. Overall then, the costs of voice are high.

At the same time the effectiveness of voice may be in doubt: the benefits to be gained by it are uncertain and (if they occur at all) expected in the future rather than the present. Thus they must be considerably discounted when measured against the certain, present benefits secured by exit.

In such a situation, which option will the dissatisfied consumer choose? At no cost exit offers the present enjoyment of improved medical care while at considerable cost voice offers only the possible, future, enjoyment of improved care. Acting on the choice assumption outlined above, the consumer will choose exit.

But in real life users do have to pay for exit: either making direct payments to the private medical sector or through the intermediary of a medical insurance organisation.<sup>44</sup> The previous argument makes it clear that the adoption of the exit option depends in part on its costs. If the cost to the consumer is high and/or the benefits to be secured by exit are negligible, it is unlikely that many people will use it. Exactly what constitutes "high" cost and "negligible" benefits is an empirical question that can only be answered by asking those affected: consumer definitions of "high" cost and "negligible" benefit are likely

to vary over time, between groups and so on.

Nevertheless, a tentative generalisation can be made about the extent to which changes in the cost of the exit option will affect its use. As Hirschman points out, quality conscious consumers are likely to be rather insensitive to price increases. When people care a great deal about the quality of the service they receive, small changes in quality will markedly affect the level of their enjoyment. Consequently such people will be willing to pay considerably more to secure even marginal improvement in the service they receive.<sup>45</sup> So long as voice appears less effective, and more costly than exit, consumers anxious to "do something" to improve the medical care they receive are unlikely to be discouraged from the use of exit by small increases in its price. Thus I expect demand for exit to be relatively price inelastic; only "steep" increases in the price of exit are likely to make much difference to its use.

#### LOYALTY AND EXIT

However non-monetary barriers to exit (in Hirschman's terms: loyalty) may also exist, thus restraining dissatisfied consumers who are otherwise willing and able to leave. First Hirschman points out that consumers may refrain from exit when a) they believe the consequences of exit to be negative for the organisation left and b) they continue (for one reason or another) to care about the output of the organisation even after they have exited.<sup>46</sup> For example,

consumers of public sector medical care realise that their exit will worsen public sector performance and moreover believe that this fact is likely to inflict significant costs on themselves. They may reason (for example) that further decline may greatly increase the chance of the outbreak of infectious diseases, a situation in which those who have and those who have not exited, are equally at risk. Thus while exit will secure them better medical care, it also increases the probability that they will suffer sickness; consequently consumers may decide not to leave.

For consumers to be restrained from exit in this way they must appreciate both the contribution their action will make to worsening public sector performance and the consequences of this fact for themselves. In the present situation both points seem in doubt. The P.S.A. has argued that the expansion of the private sector is harmful to the public sector. At the same time successive government reports and the representations of private hospitals and medical insurance companies have held that private sector expansion has been, or will be, beneficial to the public sector.<sup>47</sup> Inasmuch as those considering exit think about the matter at all, they could be forgiven for their confusion. Similarly, the linkages that may exist between public sector decline and personal costs accruing to those who exit are not obvious. Consumers are unlikely to be restrained from exit by information they do not have.

But even when consumers possess the necessary information about the consequences of exit for the public sector and believe these consequences to be undesirable, they are still likely to exit. To state the argument formally, I assume a

situation in which each person knows:

- a. that exit works to further weaken the public sector
- b. that he prefers, for one reason or another, that the public sector not be further weakened.
- c. that nevertheless, exit ensures him the personal enjoyment of significantly better medical care

What are the consequences of sticking with the public sector? First if I stay I forgo the benefits of the private sector. At the same time my decision to stay is per se unlikely to make any difference to public sector performance. Public sector performance, like that of an army in battle, only suffers when many individuals decide to flee. Thus if I stay and everyone else leaves, the public sector will still collapse. On the other hand, if everyone else stays and I leave, the public sector holds together, a fact from which I benefit equally with those who have stayed. Thus staying bars me from the enjoyment of private sector care and fails to contribute appreciably to the improvement of the public sector. My best strategy, like everyone else, is always to exit. Thus the existence of costs of this kind will deter few people from exit.<sup>48</sup>

But there is a second basis for loyalty that cannot be so easily disposed of: some people care a great deal about whether medical care is distributed through the private or the public sector, regardless of the kind of medical care they personally receive. Passionate arguments over the extent of a person's right to free medical care still go on in some quarters, and cannot be subsumed under a description

of the simple self interest of those involved. Some people (hereafter called ideologues) are ideologically (or morally) committed to the public sector distribution of medical care.

Will such a commitment stop ideologues from exiting? No simple answer can be given; the previous argument suggests that ideologues will not refrain from exit because of damage their leaving may do the public sector. On the other hand, the ideologue's calculus of value is not simply instrumental: "here I stand; I can do no other", may be the motto of some ideologues.

But the most important characteristic of ideologues is not their propensity to exit or not, but the fact that they alone have good reason to voice, even if they do exit. For ideologues, exiting solves the problem of securing better medical services for themselves, just as it does for others. But unlike others, ideologues have a second problem which remains unresolved by exit; they continue to care a great deal about how medical care is distributed. Thus ideologues may be a source of voice regardless of exit.

#### SUMMARY.

The benefits to be gained by voice remain uncertain and cannot be won immediately. At the same time the costs of using voice may be high. In contrast, exit secures certain benefits, immediately. As long as its cost is not "too high" (I have argued that consumers will tend to "undervalue" its monetary cost), consumers anxious to "do something" to improve the hospital service they receive are likely to prefer exit to voice. The existence of



"loyalty" based on the consequences of exit will make no difference to this decision. However "loyalty" stemming from ideological commitment to the public sector distribution of medical care may lead people to voice regardless of whether they exit.

#### WILL ANY VOICE OCCUR?

In these circumstances, where the overwhelming majority of dissatisfied consumers will prefer exit to voice, will any voice appear at all? Apart from ideologues, the potential agents of voice (if in fact they exist) will be drawn from the pool of people who for various reasons have not exited. First, the pool may contain people who are unaware that the quality of the public sector is less than satisfactory. For example, the fact that consumers' contact with the medical care system is often sporadic may mean that even a quality conscious person remains unaware of quality changes for sometime after they have occurred.<sup>49</sup> For whatever reason it occurs, lack of awareness precludes the possibility of dissatisfaction and thus of voice.

Second the pool is likely to contain people who care very little, if at all, about the quality of public sector care. Again such people will not become the agents of voice. Finally the pool may contain people who are dissatisfied with public sector care but unable to exit. The previous argument makes it clear that such people will be reluctant users of voice; it is likely that, in common with other dissatisfied consumers, they would have preferred to exit

if the option had been available to them.

Not being able to exit is a consequence of being too old, too sick or too poor. Medical insurance companies refuse to insure anyone over the age of 65 who is not already a member and, at least one, doubles the price of the premium paid by their current members when they reach this age. Thus the costs of exit for old people, insured or not, increases greatly at the time when retirement reduces their income and their need for medical care grows. Some old people are likely to find it difficult to stretch a newly restricted budget to cover the increased premium cost, while very few old people can afford to themselves, directly pay the costs of extensive private sector care. Thus it is likely that many old people, dissatisfied with the quality of public sector care, will nevertheless find themselves unable to exit.

Similarly medical insurance companies refuse to accept the chronically sick as members. Again such people are unlikely to be able to themselves afford to buy from the private sector the extensive medical care they need.<sup>50</sup> Thus, even if they are dissatisfied, exit is usually impossible,

Finally there are those who are too poor to exit, despite their dissatisfaction and the introduction of medical insurance. Thus other than ideologues, voices' potential agents are to be found among the old, the sick and the poor.

Such people are likely to find the use of voice extraordinarily difficult. I have already argued that in general the use of voice is costly; its outcome remains uncertain while it may involve its user in the expenditure of a considerable amount of time, energy and sometimes money.

But at the same time, the costs of voice and the likelihood of its success differ significantly from person to person. It is obvious that sick people and old people will be considerably handicapped in their use of voice. Old people especially are often bewildered and bemused by their contacts (often tenuous) with community agencies, bureacratic or otherwise. Both groups lack the energy and usually the position for the effective use of voice.

Poor people are also disadvantaged in their use of voice. The amount of use made of voice (as measured by indices of political participation) varies significantly by education, income and prestige of occupation; poor people enjoy less of these resources and make much less use of voice than richer people. Similarly the resort to voice is likely to have different consequences for rich and poor; poor people, unlike rich people, report that the use of voice makes little difference to outcomes that affect them.<sup>51</sup>

Thus the old, the chronically ill, and the poor are doubly disadvantaged in their efforts to improve the quality of medical care; effectively barred from exit, they are also likely to find voice peculiarly difficult. In such a situation simply doing nothing is almost always the most rational response.

## CHAPTER SUMMARY

Those people who are actively dissatisfied with public sector care and who can afford exit will usually choose it, rather than voice, as a remedy; ideologues constitute the

only exception to this rule (both, in that they may choose to exit rather than voice and still have reason to voice after exiting). The remainder, those people who are dissatisfied but handicapped in their use of exit and voice, will usually end up doing nothing. Thus the existence of a large amount of dissatisfaction with public sector medical care will lead to a large amount of exit but little or no voice.

But the absence of voice lessens the probability that steps will be taken to remedy public sector deficiencies, while large scale exit worsens public sector performance. As a result, the number of those dissatisfied is likely to grow further, leading to further exit and more public sector decline, and so on. At the same time the political difficulty of attempting to rehabilitate the public sector at the expense of the private grows. The more people exit, the greater the support for increasing government subsidies to the private sector and the more bitter the opposition to their removal. The more subsidies, the easier exit; the easier exit, again the more public sector decline, and so on; the vicious circle is further compounded.

If such a process were to continue long enough our institutional arrangements for the provision of hospital care would be revolutionised. Most New Zealanders would come to depend on the private sector for part or all of their hospital care; the remainder being dependent either on a severely depleted public sector or on the receipt of private charity. The discussion as to whether it is likely or even inevitable that the process I have outlined

will continue "long enough" for such a revolution to occur  
I leave to the last chapter.

# NOTES

<sup>1</sup>The term quality is used here to cover the adequacy of the supply of public sector hospital care as well as its standard.

<sup>2</sup>Albert O. Hirschman, Exit, Voice, and Loyalty: Responses to Decline in Firms, Organisations and States (Cambridge, Mass: Harvard University Press, 1970). Brian Barry points out that Hirschman's theory is applicable to all of those situations in which quality might be improved; not just situations in which quality is deteriorating. Brian Barry, "Review Article: 'Exit, Voice and Loyalty,'" British Journal of Political Science 4, (1974), 79-107, p.90.

<sup>3</sup>Hirschman, Exit, Voice and Loyalty. p.6.

<sup>4</sup>Ibid., p.30

<sup>5</sup>It is difficult to imagine someone taking out medical insurance and at the same time vowing not to use private sector facilities.

<sup>6</sup>The terms "selective benefit" and "collective benefit" are adapted from Mancur Olson Jr. See, Mancur Olson Jr. The Logic of Collective Action, (Cambridge, Mass: Harvard University Press, 1965), pp.14 and 51.

<sup>7</sup>Adam Smith's hidden hand is clearly visible in the analogous case of housing. M.P.'s find out about housing problems because people complain to them about their own difficulties in finding housing, not about the community problem of housing.

<sup>8</sup>For an account of the consequences of the use of this strategy in the context of political parties see, John M. Orbell and Geoffrey Fougere, "Intra-Party Conflict and the Decay of Ideology", The Journal of Politics, 35 (1973), 439 - 458.

<sup>9</sup>Barry points out that Hirschman does not distinguish between the motivations for the two kinds of voice. However, while the distinction is important in discussing the circumstances in which any voice will occur, motivation does not determine the consequences of voice. See, Barry, "Review Article", pp.92-93.

<sup>10</sup>Milton Friedman, "The Role of Government in Education", Capitalism and Freedom (Chicago: The University of Chicago Press, 1962). pp.85-107. For similar arguments about the beneficial effects of competition, ensuing

from the dismantling of the National Health Service in Britain, see Michael H. Cooper and Anthony J. Culyer, The Price of Blood, Hobart Paper no. 41 (London: The Institute of Economic Affairs, 1968), and D.S. Lees, Health Through Choice, Hobart Paper no. 14 (London: The Institute of Economic Affairs, 1961).

<sup>11</sup> Anthony Downs, Urban Problems and Prospects, Markham Series in Public Policy Analysis, (Chicago: Markham Publishing Company, 1970). p.264.

<sup>12</sup> Whether in reality the private sector is analogous to the orthodox economic model of it is also a moot point.

<sup>13</sup> For example, in Australia, Scotton estimates that in 1966, 15% of Australians (excluding those from Queensland) were not covered for hospitalisation by voluntary or pensioner schemes and 17% had no medical cover. See R.B. Scotton, "Membership of Voluntary Health Insurance", Economic Record, 45 (1969), pp.69-83.

<sup>14</sup> In contrast, private sector firms as well as keeping a close eye on sales figures etc., often hire the services of market research organisations to systematically discover consumer preferences. Some very large New Zealand firms have their own "in house" market research teams.

<sup>15</sup> In their submission to the Board of Health Inquiry into Private Hospitals, 1972 Southern Cross report a survey they,

conducted among a number of surgeons in Auckland in 1970. It showed that while, on average, they gave almost half of their working time to Public Hospital service, the rewards from that work accounted for only about 20% of their income, the other 80% coming from private practice undertaken during the remainder of their time.

See Southern Cross Medical Care Society, "Submissions to the Board of Health Inquiry into Private Hospitals, 1972 (mimeo.). p.8.

<sup>16</sup> R.J. Latimer, then Operational Officer, Research and Planning Unit, Department of Health, writes:

To consultants and in particular consultant surgeons whether general surgeons or other, they [waiting lists] are a guarantee of full employment. If there were no waiting lists, fewer patients would pass by the subsidised services of the private hospital. So long as consultants are employed in public hospitals on

a part time basis, they are unlikely to pursue policies in their salaried hospital role which could jeopardise that part of their living which they derive from fees in private practice .

R.J. Latimer, "Introduction" In R.J. Latimer, ed., Health Administration in New Zealand (Wellington: New Zealand Institute of Public Administration, 1969), 7-14, p.11.

<sup>17</sup> Lack of knowledge about local body candidates and the generally low turn out at local body elections may mean that the connection between performances and re-election is a loose one.

<sup>18</sup> Anthony Downs, An Economic Theory of Democracy (New York: Harper and Row, 1957), p.52. For an excellent review of the literature on governmental choice see, William C. Mitchell, "Theories of Governmental Choice: Downsian and Post Downsian Contributions." (Paper prepared for delivery at the 1971 Annual meeting of the American Political Science Association, Chicago, Illinois, September 7-11, 1971).

<sup>19</sup> The depression of the 1930's was one such occasion in New Zealand.

<sup>20</sup> This point was clearly appreciated by the first Labour government. Lovell-Smith reports that in the course of discussions with the B.M.A. (now M.A.N.Z.) about Labour's proposals for medical care,

Both Ministers [Fraser and Nash] agreed that private hospitals filled a need and saved public money and that any hospital benefits should be available in private as well as public hospitals.

See J. Lovell-Smith, The New Zealand Doctor and the Welfare State (Auckland: Blackwood and Janet Paul, 1966). p.67. The idea became official government writ with the publication of the Barrowclough Commission Report. See, New Zealand Consultative Committee on Hospital Reform. Report. (Wellington: Government Printer, 1953) pp.29-31.

<sup>21</sup> Details of government loan schemes to the private sector are contained in Private Hospitals in New Zealand, Board of Health Report Series: No 20 (Wellington: Board of Health, 1974) pp.27-29.

<sup>22</sup> A 1967 amendment to the Land and Income Tax Act made medical insurance premiums tax deductible. Thus in 1973, the state forfeited the tax payable on \$3,070,138



(members' contributions to the Southern Cross Medical Care Society) as well as the contributions made to other medical insurance organisations. For other details of Southern Cross's "Record levels of attainment in 1973" see The Press, 13 April, 1974. p.13.

<sup>23</sup>Note that this assumes that money not spent on the private sector would be spent instead on the public sector. It is possible that government may choose instead to use the money "saved" to reduce taxes, or in some other area of government spending.

<sup>24</sup>And nurses too. As well in conditions of full employment the public sector may also have difficulty in recruiting unskilled labour. Recently the Chief Executive Officer of the North Canterbury Hospital Board announced that a "laundry crisis" was forcing the Board to restrict the number of admissions from the Christchurch Hospital waiting list. Because of acute staff shortages the,

laundry has not been able to keep pace with the amount of laundry coming in. Waiting list admissions had to be stopped last weekend and this week to try and cut down on soiled linen.

Christchurch Star, 24 October, 1973.

<sup>25&26</sup>For documentation see Chapter 4.

<sup>27</sup>And specialists who stay with the public sector, even although they could earn a great deal more by private sector practice, themselves subsidise the public sector's operations to the extent of the difference between what they could and what they do earn. Thus, if private sector demand is very high, the fact that the public sector continues to function at all, depends on the altruism of specialists.

<sup>28</sup>Hirschman, Exit, Voice and Loyalty. p.47.

<sup>29</sup>Ibid., p.51.

<sup>30</sup>Some people may of course exit and still voice. The possibility is further discussed below. See also the empirical evidence in Chapter 3.

<sup>31</sup>For example the superintendent-in-chief of the North Canterbury Hospital Board (Dr L. McH. Berry) recently stated,

Complaining to the Minister of Health about North Canterbury Hospital Board institutions or services was not the best way of getting anything done.... if

people were really concerned about something they should approach him or the deputy medical superintendent....

And one of the Board members suggested that,

It should be made public that the board and its administrative officers encouraged comments and ideas from people

See, The Press, 27 April, 1974.

<sup>32</sup>The legal relationship between the government and hospital boards is spelled out in The Hospitals Act 1957 and its subsequent amendments.

<sup>33</sup>Originally the bill made hospital board members liable for spending "in reckless disregard" of the provisions of the Hospitals Act. After representations by the Hospital Boards' Association, the present wording was adopted. See, The Press, 25 October, 1974.

<sup>34</sup>Mechanic points out,

Innumerable studies have demonstrated that the poor have a greater prevalence of illness, disability, chronicity, and restriction of activity because of health problems than those of higher status, and that they have less accessibility to many types of health services and receive lower quality care.

David Mechanic, Public Expectations and Health Care (New York: Wiley Interscience, 1972). p.80. These differences persist even after the introduction of the welfare state provision of medical care. For evidence on the British situation, see for example, R.M. Titmuss, Commitment to Welfare (London: Allen and Unwin, 1968), and J.T. Hart, "The Inverse Care Law", The Lancet, (1971) pp.405-412. In New Zealand,

Districts with a low socio-economic rating in Auckland provide the greatest proportion of cases for the major hospitals.

See, A.N. Thompson and R.B. Elliott, "Factors in Hospital Usage and Morbidity in the Auckland Area", New Zealand Medical Journal, 75 (1972) pp.19-22. For information on the effect of the number of general practitioners in an area on hospital performance see G.C. Salmond, "A Comparative Study of Disease Specific Length of Stay in New Zealand Hospitals", The Department of Health New Zealand, Occasional Paper, Number 1 (Wellington: The Department of Health, 1972 mimeo.).

<sup>35</sup>See E.E. Schattschneider, The Semi-Sovereign People (New York: Holt, Rinehart and Winston, 1960).

<sup>36</sup>Alternatively governments may seek to still voice by striking at its agents: they may be imprisoned, driven into exile, discredited and so on. Such practices have been rare in New Zealand, occurring principally in times of official emergency. See for example, M.E.R. Bassett, Confrontation '51; The 1951 Waterfront Dispute (Wellington: Reed, 1972).

<sup>37</sup>Of course voice does not guarantee that remedial action will be taken by governments. First, governments are less sensitive to voice from some groups than others; National governments are more responsive to farmers' wishes and less to those of trade unionists, than Labour. Second, even if governments wish to respond to voice, they may sometimes lack the power or resources to make a difference. The only claim I make here for voice is that it does work to alert those responsible to dissatisfaction, and that it often provides incentives for them to seek out remedies.

<sup>38</sup>For an account of the attractions of urban practice for general practitioners see, Erich Geiringer, If Doctors Grew on Trees.... (Dunedin: John McIndoe Limited, 1969), pp.45-46.

<sup>39</sup>In 1963, the Federated Farmers could only quote 4 localities in which there was difficulty getting a doctor. In 1969 the Committee investigating rural shortages has conceded that there are at least 50 such places.

Ibid. p.46.

<sup>40</sup>A.W.S. Thompson, Where Should I Practice? (Wellington: Department of Health, 1973), p.10.

<sup>41</sup>This formulation of the choice assumption of "economic" man, is adapted from, John M. Orbell and Toru Uno, "A Theory of Neighborhood Problem Solving: Political Action vs. Residential Mobility", American Political Science Review, 66 (1972), 471-489, p.473.

<sup>42</sup>In fact the failure of the Federated Farmers organisation to effectively represent their members' wishes on the compulsory acquisition of wool issue led to the setting up of the rival New Zealand Sheep and Cattlemen's Association (Inc) in 1973. The information on the actions of Federated Farmers in this matter is drawn from material kindly provided by Federated Farmers.

<sup>43</sup>Public Service Association Inc., PSA Newsletter, 19 (1973) 23-72.

<sup>44</sup>As well, those insured pay a small percentage of their total hospital bill themselves. For example, Southern Cross pays 80% of the total cost computed from its Schedule of Surgical and Anaesthetic Fees, leaving its policy holders to themselves find the remaining 20%.

<sup>45</sup>Hirschman, Exit, Voice and Loyalty. pp.44-54. The same tendency for quality conscious consumers to "under-estimate" the cost of an action will also be true for voice.

<sup>46</sup>Ibid. pp.98-105.

<sup>47</sup>For example, New Zealand Consultative Committee on Hospital Reform.Report. Board of Health, Private Hospitals in New Zealand, Board of Health Report Series: No 20, (Wellington: Board of Health, 1974); Southern Cross Medical Care Society, "Submissions to the Board of Health Inquiry into Private Hospitals, 1972".

<sup>48</sup>The argument presented here is an application of the logic of the "tragedy of the commons" first advanced by William Forster Lloyd in 1833. See, Garrett Hardin, "The Tragedy of the Commons", Science 162 (1968), 1243-1248. For a related argument see Mancur Olson Jr., The Logic of Collective Action. Dawes has formalised the problem in a commons dilemma, "that has all the properties of the commons dilemma and that reduces to a prisoner's dilemma game when there are only two players". Robyn M. Dawes, "The Commons Dilemma Game: An N-Person Mixed-Motive game with a Dominating Strategy for Defection", Ori Research Bulletin, 13 (1973) 1-12.

<sup>49</sup>This fact raises special problems for political action. Because information about medical care is diffused gradually, each person finds himself more or less alone in deciding how to get better medical service. In contrast, when many people undergo a similar deprivation all at the same time, knowledge that others face a similar situation would seem much more promising for the emergence of political action as a remedy. This idea is discussed further in Chapter 4.

<sup>50</sup>For a review of the conditions under which medical insurance organisations accept members see, "Private Medical Insurance, Is it Fostering a Two-Tier Health System?", Consumer Review, (1974) pp.11-19. Group schemes may be partially exempt from these strictures.

<sup>51</sup>At least according to overseas studies. For a summary of such findings see Lester Milbrath, Political Participation

(Chicago: Rand McNally, 1963); and also Gabriel Almond and Sidney Verba, The Civic Culture (Princeton: Princeton University Press, 1963). Little work seems to have been done in New Zealand to ascertain rates of political participation by income. Richard Thompson shows how the poor and old in Christchurch do significantly worse than others in stopping their homes being taken for motorways, and in winning adequate compensation for them. See, Richard Thompson, Planners, Motorways and People. (Christchurch: Department of Psychology and Sociology, 1973)

## CHAPTER 2: METHODS OF DATA COLLECTION

As Friedman points out the test of a good theory is not how likely its assumptions sound (he argues that the best theories will always begin with the most unlikely assumptions) but how accurately the hypotheses derived from it describe the real world.<sup>1</sup> Here I outline the processes involved in collecting data to test my argument.

The variety of phenomena referred to by the argument multiplies the usual difficulties of data collection. In testing it I have drawn on a number of sources of information, ranging from accounts given by medical care consumers, to official statistics describing public sector performance. Similarly, I have used several research strategies, including structured interviews, content analysis and mail questionnaires.

Like all researchers I have been faced with constraints imposed by strictly limited amounts of time, energy and money. Thus in choosing between research strategies my criterion has been, "How best can I use my limited resources to ground the argument" rather than simply, "how best to ground the argument". In what follows, I have tried to give an account of some of the strategies forgone, as well as describing the research strategies I actually used.

#### THE SURVEYS.

Three surveys were completed: the first (and major one) involved interviewing consumers of medical care, the second and third, mail questionnaires sent to parliamentarians and members of the North Canterbury Hospital Board

respectively.

### The Survey of Medical Care Consumers.

Sometimes the best and occasionally the only way, to collect information about different groups of people is to ask the people themselves, about their activities, beliefs, resources and so on. Through the consumer survey I sought to answer a variety of questions including who (if anyone) is dissatisfied with public sector care; what (if anything) do they do to remedy their dissatisfaction; and what political resources and how much political energy do they have?

Because I preferred to use interviewers rather than mail out questionnaires the survey population(s) had to be contained within the Christchurch urban area.<sup>2</sup> But who to interview?

#### Choice of Population

The most obvious choice was to draw a random sample of the adult population of Christchurch. I needed no one's permission to draw such a sample. Further, from the sample, I would have been able to make precise statements about the numbers and kinds of people dissatisfied with the public sector, the total incidence of voice in the community and so on. But the crucial hypotheses deal with the actions taken by those who are dissatisfied. I expected that many, if not most, people in Christchurch would have no firm opinion about the quality of medical care. Thus to find a sufficient number of dissatisfied people to test my hypotheses I would have had to interview a prohibitively large number of respondents.

The second strategy was to look for groups whose



incidence of dissatisfaction was likely to be high. The first such group were those who had actually taken out medical insurance; if my argument was correct they should be representative of those people whose dissatisfaction led them to exit.

The second such group were those people on public hospital waiting lists. Waiting lists appeared to have two important attributes.

- a. They list the names of those, who, of all the people seeking attention for medical condition Y (where Y is any medical condition that appears on the waiting list), find exit difficult, impossible or (although free to exit) choose not to. Because a wide variety of conditions are subsumed under Y the names cover men and women in all age groups. Also the attribute "not exiting" is given by people's own behaviour in concrete situations, rather than being arbitrarily affixed by the researcher.
- b. They list the names of those, who, of all the people who potentially do not exit, have the most personal and immediate reasons for being dissatisfied with public sector quality.<sup>3</sup>

Interviewing the medical insurance group would allow me to trace the crucial connections between dissatisfaction and exit and between exit and subsequent voice. Interviewing the waiting list group would allow me to systematically test the hypotheses that those dissatisfied and unable to exit would also be unlikely to voice. By putting the information

drawn from both groups together, I could find empirical referents for such concepts as "few political resources", and make sense of the context in which both groups acted.

The strategy also ran into obvious difficulties. First, it required that I gain permission from a hospital board and a medical insurance company to draw the samples. Second, it left open a number of interesting questions (for example exactly how many and what kinds of people are dissatisfied with public sector services) that could only be answered by a sample of the whole community.

The best strategy, drawing samples from the whole community, from the waiting lists and the medical insurance company files, far exceeded my available resources. Thus I adopted the second strategy: drawing waiting list and medical insurance samples.

#### Getting permission to draw the samples.

I applied to, and was granted permission by the North Canterbury Hospital Board to sample the waiting list at Christchurch Public Hospital.<sup>4</sup> Although I enclosed an outline of the areas the interviews would cover (and later the first draft of the questionnaire) with my application, the Board made no stipulations concerning the questions I could ask.

I was also granted permission by the Southern Cross Medical Care Society, to draw a sample from their files. Understandably, Southern Cross were anxious that the inquiry be "handled in a manner we can approve" and made certain stipulations about the kind of questions that could be asked. However, once a mutually agreeable questionnaire had been constructed, I was given every

assistance in drawing the sample.<sup>5</sup>

#### How many people to sample?

There are a number of rules of thumb available to guide the researcher in his choice of optimum sample size. In each case sample size is dependent on both the kind of analysis to be used and the precision with which the researcher wishes to be able to generalise; in general returns by way of increasing precision diminish sharply after quite small sample sizes are reached.<sup>6</sup> The researcher's problem is to determine how much of his resources he is prepared to expend for each increase in precision.

The number of interviewers available to me and the number of interviews they could be expected to complete reliably suggested an optimum sample size of between three and four hundred.<sup>7</sup> Such a sample size would allow me to carry out the analysis I wished to do, and provided acceptable levels of precision.<sup>8</sup>

Allowing for the usual attrition between sample drawn and interviews completed I drew a sample of 380 people: 200 from the waiting list at Christchurch Public Hospital and 180 from Southern Cross files.<sup>9</sup>

#### Drawing the sample.<sup>10</sup>

The sampling frames used were the waiting list at Christchurch Public Hospital and the lists of the Southern Cross Medical Care Society. The former holds the names of all those waiting for medical attention in hospitals controlled by the North Canterbury Hospital Board except for Plastic Surgery and Gynaecological cases. The list is

subdivided by surgical specialty. Within each specialty a person's position on the list depends on how long he has been waiting and how urgent his condition has been listed as.

The Southern Cross list was divided into names stored on a computer file (all of those with "individual" policies plus some with "group" policies) and those still stored on the original card file (all "group" policies). The computer file listed names alphabetically by locality. The card file was divided according to the "group" involved and contained all of the names in the group, regardless of locality. By following a set of quite complicated procedures (set out in full in Appendix 1) I was confident that all Southern Cross policy holders in Christchurch (with the exception of some members of small groups) were correctly represented in the sample frame.

The general procedure followed in drawing the samples (sometimes called systematic sampling) was as follows:

1. I calculated the total number of names in each sampling frame.
2. The number of names to be drawn from each category, in each sampling frame, was calculated according to the total names listed in that category. For example, 19% of the waiting list names were listed under "Orthopaedic": therefore 19% of the sample names were drawn from this category.
3. By dividing the total number of names in each sampling frame by the number of names I wanted

- to sample I calculated a sampling interval  $i$ .
4. I then picked at random a number between 1 and  $i$  as a starting point.
  5. For each category in each sampling frame I began with the starting number and then took every  $i$ th number thereafter, until the required number of names had been drawn from the category.
  6. Where the name sampled did not have a Christchurch address, I recorded instead the name of the first person "behind" (i.e. closer to the starting point) with a Christchurch address.

This sampling procedure is used as an alternative to simple random sampling when a large population is being sampled. When, as in this case, the feature by which the lists are arranged "is not related to the subject of the survey" the procedure can be treated as "approximately equivalent to simple random sampling".<sup>11</sup>

#### The interview schedule.<sup>12</sup>

Each schedule contained questions designed to elicit information about:

1. How satisfied the respondent was with the supply and standard of public sector care (questions two and three on the medical insurance schedule, questions two and six on the waiting list schedule).
2. What strategies the respondent knew of through which to remedy any grievance he had with the public sector, and which ones (if any) he had used or planned to use (questions four and five on the

medical insurance schedule and questions three and seven on the waiting list schedule).

3. How the respondent evaluated different strategies for remedying grievances presented to him by the interviewer. (question nine on the medical insurance schedule and question ten on the waiting list schedule).
4. How the respondent evaluated public and private hospitals respectively (question seven on the medical insurance schedule and question five on the waiting list schedule).
5. What loyalty (if any) the respondent felt for the public and private sectors other than because of the care they provide. (question eleven on both schedules).
6. How much political energy the respondent has. (questions twelve to eighteen on both schedules).
7. How many political resources the respondent has. (questions nineteen and twenty on both schedules).

The medical insurance schedule also contained questions concerning:

1. details of the respondents membership of the insurance Society (question one).
2. the respondents choice of hospital if not covered by medical insurance (question eight) and
3. How much extra the respondent would be prepared to pay for his insurance cover. (question ten ).

The waiting list schedule contained questions concerning:

1. details of how long on the waiting list (question one)
2. whether the respondent was considering exit or had exited as a remedy for his grievances (questions eight and nine).

Both schedules are characterised by the extensive use of open ended questions and a focus on the respondent's actions rather than his attitudes or beliefs. Use of open ended questions was dictated by a lack of any kind of systematic knowledge about how (for example) people set about remedying their dissatisfaction with the medical care they receive. The focus on behaviour arises from the discrepancy between people's actual behaviour in particular situations and their behaviour as predicted on the basis of carefully measured "attitudes".<sup>13</sup>

#### The Selection and Training of Interviewers.

The waiting list interviews were carried out by Stage 3 Sociology students as a part of their course requirements. The medical insurance interviews were done by volunteers from Sociology 1 and Sociology 3. (Medical insurance interviewers were paid at the rate of \$1 per interview). As well, I did almost fifty of the interviews myself, and friends did about the same number of others.

All interviewers were given written instructions on how to locate and interview the respondents.<sup>14</sup> In addition all interviewers attended a training session which culminated in their interviewing each other under my supervision.

The problem in any survey is to ensure that the

interviewers locate the correct respondent (rather than their next door neighbour or best friend) and accurately record the interview. The best way to ensure that this happens is to recruit interviewers, who for their own reasons, are keen to do as good a job as possible. The interviewing of the medical insurance sample was done by people (selected from a large number of volunteers) interested in the project itself, rather than the meagre amount of money to be gained by their participation in it.

The interviewing of the waiting list group was done by Stage 3 students who were happy to work hard on the project, as long as they regarded their interview load as "fair". Both groups of interviewers on their own initiative visited homes five or more times in an effort to locate straying respondents.

In addition, interviewers knew that I held information about the respondent that was also asked for in the interview schedule (for example the respondent's age, how long on the waiting list and so on). Thus, it was unlikely that misrepresentation would pass unnoticed. As the interviews were returned I checked a number of them against this information; as I confidently expected, no discrepancies were found.

#### The problem of children.

Many of the names in the waiting list sample belong to children (defined here as someone under the age of 18). In general children have to rely on their parents both to recognise and do something about problems that affect them. But which parent to interview? It is often argued that mothers are closest to their children, and do most of the



battling on their behalf. Alternatively, fathers generally have more political resources, are more familiar with the workings of bureaucracies and more often make major financial decisions than their wives; they too care a great deal about what affects their children.

Interviewers were instructed where possible to interview the husband rather than the wife, but to find out from the person interviewed what actions (if any) their spouse may have taken (obviously no problem arises in the case of solo parents). In this way I hoped to best characterise the political resources available to the family and accurately trace the actual incidence of voice.

#### Pretesting.

Sociology 3 students tried out and extensively criticised the first draft of the questionnaire as part of their course work. The final draft was pretested on five waiting list respondents by myself and another interviewer and again tried out by the Sociology 3 class.

#### Conducting the Interviews.

All respondents were sent letters informing them that an interviewer would call, explaining the subject of the interview and asking for their help.<sup>15</sup> The response to this suggestion gave an early clue to the differences between the groups: more than twenty of the medical insurance group rang me in contrast to one person from the waiting list group.<sup>16</sup>

The fate of each name in each sample is set out in Table 1, below.

Table 1: What happened to each respondent sampled.\*

	No. names sampl- ed.	No. names inel- igible	add- ress un- trace- able	no con- tact: wrong add- ress	no con- tact: other	re- fus- al	total att- rit- ion	no. inter- views com- pleted.
Wait- ing List Sample	200	4 (196)	11 (185)	15 (170)	9 (161)	16 (145)	55	145
Med- ical In- sur- ance Sample	179	4 (175)	3 (172)	13 (159)	24 (135)	9 (126)	53	126

\*Key:

No. names ineligible = the number of people (of those contacted by an interviewer) who no longer were on the waiting list or no longer had medical insurance.

Address untraceable = those people whose addresses could not be located on the latest U.B.D. map of the Christchurch urban area.

No contact : wrong address = those people who were no longer at the address given and who could not be traced to a new address in Christchurch.

No contact : other = those people with whom no contact was made but who were assumed to live at the address given.

Refusal = those people who were contacted but refused to be interviewed.

Total attrition = Number of interviews not carried out for any reason.

The numbers in brackets represent the total left in the sample after each successive source of attrition.

The table makes it clear that a number of those whose names were sampled could not be interviewed. For this

fact to "bias" the findings those people who were not interviewed must systematically differ from those who were; a useful (if rough) test of this possibility, is to compare the distribution of interviewed and non-interviewed on some attribute known for both groups.

In drawing the waiting list sample I recorded the age of each person whose name was drawn. Similarly in drawing the medical insurance sample I noted the kind of insurance the person had. Tables 2 and 3 below show how interviewed and non-interviewed compared on these attributes in each sample.

Table 2: Comparison between complete waiting list Sample and non-interviewed in waiting list sample.\*

	age un- known	less than 18	18-19	20-29	30-39	40-49	50-59	60-69	70+
not inter- viewed	4% (2)	27% (15)	4% (6)	29% (33)	9% (5)	13% (7)	11% (6)	4% (2)	0% (0)
Com- plete Sample	6% (12)	25% (50)	3% (2)	17% (16)	14% (27)	14% (28)	13% (26)	6% (11)	4% (7)

\*Note that ages of those actually interviewed cannot be used for comparison because parents of those under 18 were interviewed, rather than the "child" himself.

Table 3: Comparison of complete medical insurance sample, interviewed and non-interviewed, in medical insurance sample.

	Surgical benefit only	Surgical plus other benefit(s)
Complete Sample	35% (63)	65% (116)
Interviewed	37% (46)	63% (79)
Not Interviewed	32% (17)	68% (36)

In neither case do those interviewed appear to differ markedly from the sample as a whole on the attribute used (although in the waiting list sample there is a tendency for the sample to under-represent those in the age group 20-29). I conclude, tentatively, that my results would have been little different if I had been able to interview both samples in their entirety.

#### Coding the interviews

The coding frame was developed and all coding done by me, thus eliminating problems of inter-coder reliability. In developing categories for coding each open ended question I used the following procedure:

1. I read the response to the question in every second interview. Where it was apparent that the

- responses would be particularly difficult to categorise I read all responses for that question.
2. I constructed a rough set of categories, bearing on the questions I wanted to answer, and then again read through the interview responses, this time noting how well they "fitted".
  3. If there was a good "fit" (i.e. a minimum of cases falling into the "other" category) the categories were adopted. Otherwise the coding scheme was further revised and the same procedure repeated.
  4. Once a satisfactory set of categories was developed, these were applied to each response a person made to a particular question. Thus, for example, each reason that a person gave for taking out medical insurance was coded separately according to the order in which it was recorded: i.e. first response, second response and so on.

#### Survey of Parliamentarians and Hospital Board Members.<sup>17</sup>

Another way of tracking down voice (other than asking dissatisfied people if they have used it) is to check with professional listeners: in this case parliamentarians and hospital board members.

I wrote to those members of parliament, whose electorates fell within the area served by the North Canterbury Hospital Board, asking them how many (if any) complaints they had received about hospital services, how the volume of hospital complaints compared with the volume

of other kinds of complaints and what, in particular, people complained about. All members replied.

Similarly I wrote to members of the North Canterbury Hospital Board asking how many complaints they received, what the complaints were about and what board members did about them. Twelve out of sixteen board members replied. Further I required information about how hospital board members regarded the private medical sector and wrote a further letter to all board members on this subject. Eight out of the sixteen members replied.

#### CONTENT ANALYSIS OF LETTERS TO THE EDITOR.<sup>18</sup>

Still in pursuit of voice, I undertook a content analysis of all published letters to the editors of the Christchurch Star and The Press for the year from September 1, 1972 to August 31, 1973. By choosing quite a long time period, I expected to minimise the difficulties arising from the tendency of letters to cluster around different subject matters at different times. By including the General Election of 1972 in the period, I was able to focus on a period when letters to the editor bear most heavily on the question of what people want from government.

Letters were classified according to whether or not they dealt with the provision of medical care and the aspect of medical care considered. The numbers of letters in each category was then counted and comparisons made with

other categories.

#### USE OF OFFICIAL STATISTICS.

I have used official statistics to trace government policy, characterise the performance of the public sector over time and so on. Two important problems arise in any use of official statistics; relevance and accuracy.<sup>19</sup>

Official statistics are usually collected for some purpose other than the convenience of social scientists. Thus the researcher must quickly accustom himself to boom and bust: a great deal of information on some points (sometimes the ones he cares little about) and very little on others. In the present study examples of bust include the lack of systematic information on the use of private hospitals and the employment of hospital specialists.

Official statistics may also be misleading or inaccurate. For example until recently the Health Department calculated the number of doctors in the country by a formula that assumed recently dead, sick, retired and exported doctors all to be in active practice in New Zealand.<sup>20</sup> Unless the researcher is able to supervise the process through which official figures are collected he can never be absolutely sure of their accuracy. But naive mistakes can be avoided by checking the reputations of sets of statistics with expert outsiders and Health Department officials.<sup>21</sup> Overall I am reasonably confident of the accuracy of the official statistics used here.

## OTHER SOURCES OF INFORMATION.

I wrote to the principals in the Temuka "case study" reported here; drew extensively on public statements by politicians; checked through Christchurch newspapers since April 1973 for relevant material and wrote to various organisations for accurate descriptions of their current policies and activities. Finally I worked through some of the submissions to the Royal Commission on Social Security, the Royal Commission to Inquire into and Report upon Hospital and Related Services in New Zealand, and the Board of Health Committee on Private Hospitals.<sup>22</sup>

## AN EVALUATION OF THE RESEARCH DESIGN.

The authors of Unobtrusive Measures point to the defects inherent in any particular research method; for example,

interviews and questionnaires intrude as a foreign element into the social setting they would describe, they create as well as measure attitudes, they elicit atypical roles and responses, they are limited to those who are accessible and will cooperate, and the responses obtained are produced in part by individual differences irrelevant to the topic at hand.<sup>23</sup>

The researcher, rather than relying on a single "best" method should use a set of complementary methods. The authors argue that,

.. the most fertile search for validity comes from a combined series of different measures, each with its own idiosyncratic weaknesses, each pointed to a single hypothesis. When a hypothesis can survive



the confrontation of a series of complementary methods of testing, it contains a degree of validity unattainable by one tested within the more constricted framework of a single method...

...the notion of a single "critical experiment" is erroneous. THERE MUST BE A SERIES OF LINKED CRITICAL EXPERIMENTS, EACH TESTING A DIFFERENT OUTCROPPING OF THE HYPOTHESIS.<sup>24</sup>

Judged by this criteria the research design presented here is an unusually strong one; for example, three different measurement procedures are used to discover and estimate the incidence of voice, exit is checked both by the growth of medical insurance societies and interviews with different groups of people and so on.

Most often the use of multiple measurement procedures has yielded inconsistent and disappointing results; when this is not the case there is reason to have a great deal of confidence in the hypotheses tested.<sup>25</sup>

# NOTES

<sup>1</sup>Milton Friedman, "The Methodology of Positive Economics", Essays in Positive Economics (Chicago: University of Chicago Press, 1953).

<sup>2</sup>The use of interviewers usually produces better response rates than mail questionnaires. As well the extensive use of open ended questions would have been impossible in a mail questionnaire, and the questionnaire would also have had to have been much shorter.

<sup>3</sup>It is a cruel commonplace that people care much more about the deprivations they personally suffer than those of strangers.

<sup>4</sup>The waiting list at Christchurch public hospital lists the names of all of those waiting for public hospital care, except gynaecological and plastic surgery cases.

<sup>5</sup>In a letter dated 24th May 1973, the general manager of the Southern Cross Medical Care Society wrote:

We will be glad to co-operate to the maximum extent we consider possible but this will be governed largely by the type of question you will be asking and the general pose struck by the overall survey. For example, I do know that we would need to be assured that the survey would not include any suggestion implying that our members had joined because they were dissatisfied with the public sector...

We would also not wish to have any reference made to member's attitude towards higher premiums or the tax deduction situation as this could well give the impression that such moves are contemplated when of course they are not, or that we are sounding out the possibility of doing so...

We will of course be glad to supply names and addresses of members provided that your inquiry is handled in a manner that we can approve .

Their justifiable caution notwithstanding, Southern Cross were at all times helpful and accomodating (for example, the requirement that I not ask about premiums was dropped).

<sup>6</sup>See for example, C.A. Moser and G. Kalton, Survey Methods in Social Investigation, 2nd ed. (London: Heinemann Educational Books Ltd, 1971) pp.146-151; Bernard Lazewitz, "Sampling Theory and Procedures", in Hubert M. Blalock and Ann B. Blalock ed., Methodology in Social Research (New York: McGraw-Hill Book Company, 1968) pp.285-287; Johan Galtung, Theory and Methods of Social Research, revised

ed. (New York: Columbia University Press, 1969). pp.48-67.

<sup>7</sup>Every New Zealand social scientist has heard stories about interviewers filling out questionnaires in the pub. To reduce the chances of this, I made sure that the sample size was such that none of students doing the interviews as part of a course requirement, would have to do more than four half hour interviews each.

<sup>8</sup>A procedure for estimating sample size according to the kind of analysis the researcher wishes to do is set out in Johan Galtung, Theory and Methods of Social Research pp.59-62. Given a minimum requirement of 10 units per cell, the minimum sample size for the simultaneous analysis of three variables, each of which has three values is 270. The problem of precision is an interesting one. Most of the generalisations I wished to make, were based on survey and other data (for example, evidence from a number of sources, only one of which is the survey, is used to estimate the incidence of voice.) Thus, even where a sample size much lower than the one I actually used, is chosen, if the evidence drawn from other sources is consistent with the survey information, there would be every reason to be confident of the findings.

<sup>9</sup>It is widely rumoured that public hospital waiting lists contain the names not only of those people waiting for attention but also those of people who have died, moved away or gone to a private hospital, and thus (for one reason or another) would have been ineligible for the survey. I therefore took the precaution of drawing a larger sample from this group; as it turned out this was unnecessary; if anything the medical insurance list was less adequate as a sampling frame than the waiting list. I assume that this reflects the effectiveness of government attempts to reduce waiting lists by clerical review.

<sup>10</sup>See appendix 1 for a detailed description of the sampling frames used and the procedures followed in drawing the samples.

<sup>11</sup>C.A. Moser and G. Kalton, Survey Methods, p.83.

<sup>12</sup>Appendix 2 contains a copy of both interview schedules, a copy of the letter sent to those to be interviewed and a copy of the instructions issued to interviewers.

<sup>13</sup>The classic study on the discrepancy that arises between attitudes and actions remains, R.T. LaPiere, "Attitudes vs. actions", Social Forces 14 (1934), pp.230-237.

<sup>14</sup>See Appendix 2.

<sup>15</sup>See Appendix 2.

<sup>16</sup>Most of the calls were either to arrange a definite time

for the interview or to report that the respondent would be on holiday or otherwise unavailable.

<sup>17</sup>Appendix 3 contains copies of the letters sent to hospital board members and members of parliament.

<sup>18</sup>In a much quoted definition, Berelson defines content analysis as,

a research technique for the objective, systematic and quantitative description of the manifest content of communication .

See, Bernard Berelson: Content Analysis in Communication Research, (New York: The Free Press, 1952)

<sup>19</sup>Governments and government departments often have a vested interest in producing as rosy a view as possible of a situation. Thus wildly improbable figures may be accepted at face value and attempts to introduce change in misleading methods of data collection resisted. For a nice account of the problem in relation to medical care in New Zealand see, Erich Geiringer, If Doctors Grew on Trees.....

<sup>20</sup>Ibid.

<sup>21</sup>For example, it turned out that one set of figures I had used to calculate some preliminary data about hospital staffing, reflected the compiler's confusion between the numbers of doctors actually employed by a hospital and the number of approved positions for doctors; the latter being a considerably higher figure.

<sup>22</sup>I wrote to each of the organisations and individuals who gave submissions to the Board of Health Committee on Private Hospitals, requesting a copy of their submission. The Department of Health kindly allowed me to see the submissions made to the Royal Commission to Inquire Into and Report upon Hospital and Related Services in New Zealand and some of the submissions to the Royal Commission on Social Security were either made available to me or were in published form.

<sup>23</sup>Eugene J. Webb et al., Unobtrusive Measures: Nonreactive Research in the Social Sciences (Chicago: Rand McNally & Company, 1966). p.1.

<sup>24</sup>Ibid., p.174

<sup>25</sup>Ibid., p.5.

CHAPTER 3: THE INCIDENCE OF EXIT AND VOICE.

Discussion of the data is broken into two chapters; in this chapter I look at possible solutions to the puzzle, "why no voice?", and in the next describe its consequences.

#### WHY NO VOICE?

These days it is difficult for anyone not to know of the dislocations occurring in the provision of public sector care. Quite apart from first hand experience, information on long waiting lists, shortages in the supply of doctors, and so on, has been widely reported in the media; even the New Zealand Woman's Weekly recently devoted its two lead pages to the announcement, "Godzone's Medicare Has Almost Gone".<sup>1</sup>

Neither are the results of public sector deficiencies always trivial. Less than a month after the appearance of the Woman's Weekly article, the Auckland coroner was moved to comment on the death of a twelve year old child that,

he was aware that the hospitals were short of beds and understaffed but there seemed to have been an increase in the number of cases this year in which persons refused admission had been sent home where they died.<sup>2</sup>

Pluralist democratic theorists are quite explicit about what should happen. Dahl's Homo Civicus might be an apolitical chap most of the time, but when his primary goals are threatened (in this case his "primordial quest" for "release from pain") he is likely to "set out deliberately to use the resources at his disposal in order to influence

the actions of governments".<sup>3</sup>

But at least in the main centres, where the situation is worst, there is little overt evidence of a citizenry dissatisfied with the provision of public sector care. No angry questions have been asked at hospital board meetings, no organisations (with the possible exception of the Public Service Association) have dedicated themselves to repairing public sector lapses and so on. Homo Civicus remains quiet.

One simple explanation is that despite deficiencies, people are perfectly satisfied with the quality of care provided by the public sector; thus no one is aroused because there is nothing to be aroused about. What evidence is there to support my argument that many people are dissatisfied with the present provision of public sector hospital care?

#### EVIDENCE FROM THE MEDICAL INSURANCE SURVEY.

Respondents were asked, "What do you see as the advantages to you of having medical insurance?" Their replies, listed in the order in which they were given are set out in Table 4 below.

Respondents were also asked to decide how important three factors (being sure of getting into hospital, the standard of medical care in private hospitals, being able to choose my own surgeon) had been in their decision to take out medical insurance. The results are set out in Table 5 below.

Table 4: Responses to the question, "What do you see as the advantages to you of having medical insurance?"

Reason Mentioned	1st response	2nd response	3rd response	4th response	Total number giving reason.
Not having to wait	84 (67%)	5 (4%)	0 (0%)	0 (0%)	89 (71%)
Tax exemption	20 (16%)	4 (3%)	1 (1%)	0 (0%)	25 (20%)
Saving on Dr and hospital bills	5 (4%)	16 (13%)	1 (1%)	0 (0%)	22 (18%)
Choice of Surgeon	2 (2%)	16 (13%)	3 (2%)	0 (0%)	21 (17%)
Attractions of private other than choice of surgeon	2 (2%)	5 (4%)	3 (2%)	2 (2%)	12 (10%)
No advantages at all	2 (2%)	0 (0%)	0 (0%)	0 (0%)	2 (2%)
Other	10 (8%)	7 (6%)	3 (2%)	1 (1%)	21 (17%)
Don't Know	1 (1%)	0 (0%)	0 (0%)	0 (0%)	1 (1%)
No answer	0 (0%)	73 (58%)	115 (91%)	123 (98%)	-
Total	126 (100%)	126 (100%)	126 (100%)	126 (100%)	-



Table 5: Importance of three given reasons in the decision to take out medical insurance.

Reason Suggested	Ranking of importance of Reason given						Total
	Very Impt.	Quite Impt.	Not very Impt.	Not Impt. at all	Don't know	No answer	
Being sure of getting into hospital	78 (62%)	29 (23%)	8 (6%)	9 (7%)	0 (0%)	2 (2%)	126 (100%)
Because of the quality of medical care	22 (17%)	22 (17%)	30 (24%)	45 (36%)	4 (3%)	3 (2%)	126 (100%)
Being able to choose my own surgeon	51 (40%)	28 (22%)	27 (21%)	19 (15%)	0 (0%)	1 (1%)	126 (100%)

From Table 4, it is clear that those interviewed use medical insurance as a means of remedying their dissatisfaction with the public sector.<sup>4</sup> The chief source of dissatisfaction is the inadequate supply of public sector care; "not having to wait" is seen as an advantage by 71% of the respondents (67% giving it as their first response). In contrast 17% and 10% mention "choice of surgeon" and "attraction of private sector (other than choice of surgeon)" respectively (and in both cases only 2% gave it as their first response).

Unsurprisingly, the information in Table 5 is consistent with this argument; 85% of the respondents cite "being sure of getting into hospital" as an important reason for taking out medical insurance, while only 34% cite "the

standard of care in private hospitals". However, with a prompt from the interview, "choice of surgeon" becomes more important to respondents in Table 5 than in Table 4.<sup>5</sup>

Further evidence that most respondents are not dissatisfied with the standard of medical care in public hospitals is given in Table 6 below. Only 25% of the respondents believe unequivocally, that private hospitals provide better care, while 35% believe that there is no difference, and 10% think that public is best. Respondents were asked,

"In general, do you think that public hospitals provide better care than private hospitals, private hospitals provide better care than public, there is no difference, or that it depends?"

Table 6: What kind of hospital provides the better care?  
(Medical Insurance Sample)

Hospital with best care	Public best	Private best	No difference	It depends	Don't know	No answer	total
No. giving this response.	12 (10%)	32 (25%)	44 (35%)	33 (26%)	5 (4%)	0 (0%)	126 (100%)

I conclude that people who take out medical insurance do so because they are dissatisfied with public sector medical care. Because a great many people have, or are about to have, medical insurance, it follows that a great many people are dissatisfied with public sector medical care.

The major source of their dissatisfaction is the supply, rather than the standard, of public sector care;

their concern is not that they will be badly looked after in a public hospital, but that they will be unable to get into one when they want to.<sup>6</sup> As well some people (between 20% and 80% of the sample depending on the question asked) are dissatisfied that the public sector does not allow them to choose their own surgeon.

#### EVIDENCE FROM THE WAITING LIST SURVEY.

The analysis of the waiting list interviews reveals further evidence of dissatisfaction. Again (see Tables 7 and 8) the source of dissatisfaction is the inadequate supply, rather than the standard, of public sector care. Table 7 shows that, while almost half the waiting list sample are dissatisfied with having to wait, only about one tenth of them are dissatisfied with the standard of public sector care. Similarly it is clear from Table 8, that only about one fifth of those interviewed unequivocally believe that the private sector provides better care.

#### SUMMARY.

Data from both series of interviews supports the hypothesis that many people are dissatisfied with the provision of public sector hospital care; the most important reason for dissatisfaction being inadequate supply. Thus the absence of voice is not explained by the absence of dissatisfaction.

Table 7: How those on the waiting list feel about having to wait and the standard of public sector care.

Question:	fully satis- fied.	reason- ably satis- fied.	some- what dis- satis- fied.	very dis- satis- fied.	don't care. know.	don't know.	no answer.	total.
How do you feel about this wait?	14 (10%)	51 (35%)	47 (32%)	23 (16%)	6 (4%)	0 (0%)	4 (3%)	145 (100%)
In general how do you feel about the standard of medical care in public hospitals once you get into them?	71 (49%)	44 (30%)	11 (8%)	5 (3%)	3 (2%)	4 (3%)	7 (5%)	145 (100%)

Table 8: Which kind of hospital provides better care?  
(Waiting list Sample)

Hospital with best care	Public best	Private best	No differ- ence	It depends	Don't know	No answer	Total
No. giving this response.	47 (32%)	27 (19%)	37 (26%)	20 (14%)	13 (9%)	1 (1%)	145 (100%)

THE AVAILABILITY AND RELATIVE COST/EFFECTIVENESS OF VOICE  
AND EXIT: THE COST/EFFECTIVENESS OF VOICE.

In chapter 1 I argued that the absence of voice is best explained by the availability of exit and its favourable cost/effectiveness relative to voice. To provide an empirical

referent for the concept of "cost/effectiveness of voice"  
those interviewed were asked:

1. Is there anything people like you can do to increase the chances that they get into a public hospital when they want to? and
2. Is there anything that people like you can do to improve the standard of medical care in public hospitals?.

The distribution of responses for both samples is set out in Table 9 below.

Table 9: Is there anything that can be done to increase the supply or improve the standard of public sector care?

Question	Yes	No	Don't know	No answer	Total
Increase Medical supply?	34(27%)	91(72%)	0(0%)	1(1%)	126(100%)
Insurance					
Waiting List.	34(23%)	105(72%)	4(3%)	2(1%)	145(100%)
Improve Medical Standard?	34(27%)	89(71%)	0(0%)	3(2%)	126(100%)
Insurance					
Waiting List	41(28%)	96(66%)	6(4%)	2(1%)	145(100%)

Table 9 shows that less than 30% of those interviewed know of any voice strategy that works to improve public sector care. Voice fails to work (see Table 10) either because the situation is such that no one could do anything about it (constrained by situation), or because they personally, (or

people like them), are unable to make any difference (personal impotence).<sup>7</sup>

In addition, a number of people interpreted the question on the standard of public sector care as implying that the standard was unsatisfactory; they then refused to answer further than that the standard was very high, and thus the question of what to do to improve it, meaningless. The failure of the supply question to create a similar reaction further supports my contention that dissatisfaction centres on the supply, rather than the standard of public sector care. (see Table 10).

Analysis of the "voice" responses reveals that my original estimate of the number who know of effective voice strategies is too high. Despite the most generous possible construction of what constitutes voice, at most 21% of the medical insurance sample and 19% of the waiting list sample report knowing ways of affecting the supply of public sector care and 17% and 16% respectively, ways of affecting the standard of care: i.e. "true" voice (see Table 11 below).

I further analysed the "true" voice responses according to whether they were likely to result in actions being taken to upgrade public sector services in general (collective benefits) or simply result in a selective benefit accruing to the person voicing. As a rough rule of thumb, I coded all responses aimed at political actors (including hospital board members) as likely to bring about collective benefits, and those aimed at others as likely to bring about selective benefits. The results are presented in Table 12 below. Clearly, few people in either sample reported knowing a

voice strategy likely to bring about general public sector improvement (cf., the difference between the numbers in the medical insurance, and the numbers in the waiting list sample suggesting political strategies as a remedy for public sector defects).

Table 10: Reasons why voice strategies do not work.

Reason	Supply		Standard	
	Medical Insurance	Waiting List	Medical Insurance	Waiting List
Personal Impotence	72 (79%)	70 (67%)	52 (58%)	72 (75%)
Constrained by situation	16 (18%)	26 (25%)	4 (5%)	42 (10%)
Supply/Standard O.K.	1 (1%)	1 (1%)	27 (30%)	19 (20%)
Other	3 (3%)	19 (18%)	3 (3%)	0 (0%)
Don't know	0 (0%)	3 (3%)	2 (2%)	2 (2%)
No answer	2 (2%)	2 (2%)	3 (3%)	3 (3%)
Total responses	94	121	91	106
Total Respondents	91 (100%)	105 (100%)	89 (100%)	96 (100%)

Each voice strategy that is mentioned is fraught with uncertainty. Neither contacting a member of parliament, working through a political party, nor vetting hospital board candidates at election time (all coded as "political" strategies) guarantees anyone better medical care. Doctors and hospital

administrators approached (coded as "medical" strategies) may often be too busy to listen or unable to respond even if they wish to. Strategies such as "writing a letter to a newspaper", "signing a petition", "complaining to someone", (all coded as "voice strategies: aim not clear") do not guarantee redress.

Table 11: Analysis of Voice responses.

Responses	Supply		Standard	
	Medical Insurance	Waiting List	Medical Insurance	Waiting List
"True" voice responses	26	28	22	23
Other responses (including no answer, don't know)	9	11	12	23
Total no. of responses	35	39	34	46
Total no. of respondents	34	34	34	41
No. suggesting "true" voice strategy as % of total sample. *	26 (21%)	28 (19%)	22 (17%)	23 (16%)

\*Note that this number is calculated on the assumption that each respondent giving a "true" voice response, gave one response only: thus it represents the maximum possible number in each sample giving "true" voice responses.



Table 12: Voice responses and collective benefits.

Voice Strategies	Supply		Standard	
	Medical Insurance	Waiting List	Medical Insurance	Waiting List
Pressure political authorities (including hospital board members)	15	1	13	6
Pressure medical authorities	5	16	4	5
aim unclear	6	11	5	12
Total no. of responses	26	28	22	23
No. suggesting "political" strategy as % of total sample.*	15 (12%)	1 (1%)	13 (10%)	6 (4%)

\*Note that this number is calculated on the assumption that each respondent giving a "political" strategy response gave one response only; thus it represents the maximum possible number in each sample giving a "political" strategy response.

Respondents' belief in the uncertain outcome of voice is reflected in their evaluation of each of eleven different voice strategies (See Table 13). The Table shows that most respondents are doubtful that any of the strategies will make much difference. Together the categories "great deal of difference" and "some difference" include 50% or more of medical insurance respondents only three times out of eleven and waiting list respondents only one time out of eleven.

The outcomes of these comparatively "sure fire" strategies (working through an organisation, working through a political party and complaining to an M.P.) are clearly not guaranteed. (Cf. the difference in evaluation of strategies between the two samples; only on the direct action item, are those in the waiting list sample more optimistic than those in the medical insurance sample).

It is difficult to estimate the actual time, energy and money expenditure required by the voice strategies mentioned. First, voice strategies include activities as diverse as "complaining to someone", "getting on to the doctor", and "working through a political party". Second, the widespread response to some of the interview questions, "I'm not the complaining type", suggests the cost of voice may include the price of deviance. And finally, the uncertain outcome of each voice strategy means that the expenditure of any effort on voice may be judged as "just a waste of time".

## SUMMARY

Most respondents in both samples (approximately four fifths) report that they do not know of any way in which they can affect the supply, or the standard of public sector care: in the present context voice is simply not an option for them. Of the voice strategies that are suggested, all are characterised by a great deal of uncertainty. Thus, the cost/effectiveness ratio of voice appears unfavourable; even a great deal of energy does not guarantee a successful outcome.

Table 13: Evaluation of suggested voice strategies.

Complaining to/ working through/ using.	Sample	Make a great deal of difference or some difference.	
		No.	% of sample
Hospital Superint- endent.	Medical Insurance	59	(47%)
	Waiting List	46	(32%)
Hospital board	Medical insurance	54	(45%)
	Waiting list	45	(31%)
Family doctor	Medical insurance	44	(35%)
	Waiting list	44	(30%)
Ombudsman	Medical insurance	54	(43%)
	Waiting list	48	(33%)
Organisation (e.g. church, union, plunket)	Medical insurance	65	(52%)
	Waiting list	70	(48%)
Political party	Medical insurance	67	(53%)
	Waiting list	72	(50%)
Direct action (strikes) protests etc)	Medical insurance	19	(15%)
	Waiting list	41	(28%)
Health Department	Medical insurance	61	(48%)
	Waiting list	64	(44%)
Member of Parliament	Medical insurance	70	(56%)
	Waiting list	56	(39%)
Cabinet Minister	Medical insurance	52	(41%)
	Waiting list	48	(33%)
Letter to newspaper	Medical insurance	52	(41%)
	Waiting list	55	(38%)
Total sample size	Medical insurance	126	(100%)
	Waiting list	145	(100%)

THE AVAILABILITY AND RELATIVE COST/EFFECTIVENESS OF VOICE  
AND EXIT: THE MONETARY COSTS OF EXIT.

At least at present, exit is guaranteed to bring about immediate improvements in hospital service to the person using it. Thus the effectiveness of exit is given: here I am concerned to assess its costs.

In chapter 1 I argued that medical insurance makes exit financially possible for people who could not otherwise afford it. As well, those who exit are likely to "under-value" its costs; thus they will be relatively insensitive to price increases.

The annual cost of Southern Cross's surgical benefit ranges from \$10.50 to \$29.40; for the medical and surgical benefits combined from \$24.50 to \$69.40 (the cost in each case is for coverage for a single adult, the highest for coverage for a family of husband, wife and two or more children under 19).<sup>8</sup>

Of those interviewed 20 (16%) had their contributions subsidised by their employers, the average rate of subsidy reported being 65%. The mean amount paid personally by all respondents for their coverage (calculated on the basis of respondent reports) was \$38.

Table 14 shows that many of those interviewed are in fact relatively insensitive to increases in the price of exit; more than half of the respondents reporting themselves willing to pay premiums half as high again as their present ones.

Table 14: Willingness to pay higher premiums.

	$\frac{1}{4}$ as much again	$\frac{1}{2}$ as much again	2x as much again
number and %	93 (74%)	70 (56%)	41 (33%)

However, the facts that medical insurance lowers the absolute costs of exit, and that consumers tend to "under-value" these costs, does not necessarily mean that medical insurance has led to the use of exit by people who previously could not afford it. To find out the extent to which the medical insurance sample contained people who, without insurance, would find it difficult to afford exit, I asked, "if you did not have medical insurance and needed to go to a hospital would you go to a private or a public hospital or would it depend?" (see Table 15).

Table 15: Choice of Hospital if uninsured.

	go to public	go to private	it depends	don't know	no answer	total
number and %	37 (30%)	22 (17%)	66 (52%)	0 (0%)	1 (1%)	126 (100%)

Of the 37 people reporting they would use the public sector, 24 (19% of the medical insurance sample), said that they could not afford private sector care; of the 66 reporting that it would "depend" the crucial factor for

21 of them (17% of the medical insurance sample) was their personal liquidity. Thus the survey evidence supports the contention that medical insurance has worked to make exit more widely available.

But still not everybody can exit. I pointed out in Chapter 1 that medical insurance is not available to the chronically ill or (as Table 16 below shows) to most old people.

Table 16: Age distribution of medical insurance respondents.

	20-29	30-39	40-49	50-59	60-69	70+	Total
Number	13	24	31	33	24	1	126
and %	(10%)	(19%)	(25%)	(26%)	(19%)	(1%)	(100%)

Similarly the fact that even the modest cost of medical insurance premiums may be beyond the means of a large number of New Zealanders, is reflected in the predominance of high incomes among those insured. (see Table 17 below).

#### SUMMARY.

Medical insurance effectively lowers the cost of exit, making it available to many more people than previously; the survey provides evidence that a number of the insured could not afford exit otherwise. At the same time, inspection of the age and income groups in which the medically insured occur, makes it clear that the old and the poor remain largely excluded.

Table 17: Income distribution of medical insurance respondents.

Annual income of family	Number and %
less than \$2,000	6 (5%)
\$2,000-\$2,999	8 (6%)
\$3,000-\$3,999	17 (13%)
\$4,000-\$4,999	17 (13%)
\$5,000-\$5,999	17 (13%)
\$6,000-\$6,999	8 (6%)
\$7,000-\$7,999	12 (10%)
\$8,000-\$8,999	4 (3%)
\$9,000-\$9,999	4 (3%)
\$10,000-\$10,999	5 (4%)
\$11,000-\$11,999	1 (1%)
\$12,000+	13 (10%)
Don't know	4 (3%)
No answer	10 (8%)
Total	126 (100%)

THE AVAILABILITY AND RELATIVE COST/EFFECTIVENESS OF VOICE  
AND EXIT: LOYALTY AND EXIT.

In chapter 1, I argued that few people will consider themselves wedded to the public sector for better or for worse; that people who are dissatisfied with the public

sector will usually not be restrained from its use by loyalty (or non-monetary costs).

I suggested that the grounds for loyalty to the public sector (except perhaps for past good performance) are unclear. First, the consequences of exit for the public sector are disputed; the Barrowclough report and the Board of Health Committee Report on Private Hospitals arguing that private and public hospitals are complementary, private hospitals relieving the burden on the public sector.<sup>9</sup> Similarly the present Minister of Health recently stated that the Labour government, "saw private hospitals filling a complementary role in medical services".<sup>10</sup> On this basis, exit may well be the first choice of the loyalist hoping to preserve, or improve, the public sector; by exiting he helps reduce demand for public sector services and thus, presumably, improves the quality of care received by those remaining.

Alternatively, loyalists may be swayed by the arguments advanced by the Public Service Association and Dr Sutch who have suggested that the consequences of exit, or at least government encouragement of it, are detrimental to the public sector.<sup>11</sup>

But even if people are clear about their loyalty, and the action it entails, I argued that they would still be likely to choose exit. As Table 18 shows, no one in the waiting list sample who reported himself dissatisfied with public sector care, gave ideological commitment to the public sector as a reason for not going to a private hospital; similarly, only one person cited an ideological reason for not taking out medical insurance. (Here,



ideological reason covers any response that suggests that a person refrains from exit because of the consequences of his actions for the public sector, or because of his adherence to an ideological or moral injunction prohibiting exit). In contrast, the monetary cost of exit is an often cited reason for not using the option.

Table 18: Reasons given for not exiting by those in the waiting list sample reporting themselves dissatisfied with public sector care.

Reasons for not exiting				
Reason given for not:	on grounds of cash (monetary)	on ideological grounds	other (including don't know, no answer)	Total Respondents
going to a private hospital	25 (58%)	0 (0%)	18 (42%)	43 (100%)
not taking out medical insurance	11 (26%)	1 (2%)	31 (72%)	43 (100%)

#### SUMMARY

Overall, non-monetary factors are far less often cited than monetary factors as a reason for not exiting. Thus few people seem likely to be restrained from exit by loyalty.

## THE COST/EFFECTIVENESS OF EXIT AND VOICE COMPARED.

In the preceding two sections I have presented data bearing on what people consider to be the cost/effectiveness of exit and voice. Here my concern is to give the notion a more precise empirical content by evaluating the cost and effectiveness of each option relative to the other.

The person who exits can be certain that he will enjoy the benefits that he seeks through the action. In contrast, for most people, the only thing certain about their use of voice is that it will bring them no benefits at all.

That exit secures certain benefits means that it is relatively easy to calculate the effort required for the action and to decide whether it is "worth it". The monetary cost of exit is low enough to make it quite widely available, while it appears that few people bear non-monetary (loyalty) costs in exiting. The exit option, at least in the form of medical insurance, is sold to the recipient; thus he need expend little or no time and energy in finding out how to exit. And finally the use of exit entails no opportunity costs; the person who exits in no way gives up his rights to make what use he wishes of the public sector.

In contrast, the belief that the outcome of voice is at best uncertain, makes it difficult to calculate whether the strategy is worthwhile. Voice is not sold to anyone; the time, energy and money, expenditure required to use it with any hope of effectiveness may be considerable, and is usually difficult, if not impossible to calculate in

advance. Finally, inasmuch as a person chooses to voice rather than exit, he forgoes the certain benefits exit promises. (Below I examine the possibility that a person may exit and still voice; in such a case the opportunity costs incurred in forgoing exit do not apply).

Of course, the relative costs of voice and exit may be subject to drastic change. In the same way that medical insurance has considerably lowered the costs of exit, a social innovation may dramatically lower the cost of voice. As Hirschman points out, "the possible discovery of lower cost and great effectiveness is of the very essence of voice".<sup>12</sup>

Nevertheless, those people who currently can afford either exit or voice (I have argued that medical insurance makes exit widely available) will find that the relative cost of voice greatly exceeds that of exit. For those unable to exit (or choosing not to) the high cost of voice will discourage its use. In such a situation I have argued that the incidence of exit will greatly exceed that of voice.

#### THE WAITING LIST AS A CHOICE SITUATION: EXIT OR VOICE?

In choosing to sample the waiting list I assumed first, that those on it would have pressing and personal reasons for wanting to "do something" to improve the supply and perhaps the standard of public sector care. Second, I expected that being on the waiting list (rather than being in a private hospital) was a consequence of exit being difficult or unavailable. In fact it turned out that a

good number of those on the waiting list, if unable to exit this time, planned to, or had already, taken out medical insurance so as to avoid the waiting list in future.<sup>13</sup>

Thus contrary to my initial expectations, many of those found on the waiting list had a real choice between exit and voice. Which did they choose?

On average the use of either option was considerably more difficult for members of the waiting list sample than members of the medical insurance sample. As Table 19 below shows, the incomes of waiting list respondents are concentrated toward the bottom of the scale, while those of the medical insurance respondents are found largely toward the top; the mean income of waiting list respondents of \$4,428 compares unfavourably with the medical insurance mean of \$6,241. Thus it is more difficult for those on the waiting list to find the money to pay insurance premiums.<sup>14</sup>

The waiting list group was short as well on education (mean age education ended 15.5 years, compared with 17.3 years for the medical insurance sample) and occupational prestige (the median status ranking fell between categories 5 and 6, compared with 4 and 5 for the medical insurance sample) which along with income I have earlier identified as important political resources (see Tables 20 and 21 below). Thus the use of voice may also be more difficult for waiting list respondents. (In line with this, I showed in Table 13 that those in the waiting list sample were generally less optimistic about the use of voice than the medically insured and in Table 12 that they were less likely than the medically insured to suggest political strategies as a remedy for dissatisfaction

with public sector services.)

Table 19: Income distribution: waiting list and medical insurance respondents compared.

Annual income of family	Medically insured	Waiting list
less than \$2,000	6 (5%)	23 (16%)
\$2,000-\$2,999	8 (6%)	8 (6%)
\$3,000-\$3,999	17 (13%)	30 (21%)
\$4,000-\$4,999	17 (13%)	23 (16%)
\$5,000-\$5,999	17 (13%)	27 (19%)
\$6,000-\$6,999	8 (6%)	16 (11%)
\$7,000-\$7,999	12 (10%)	8 (6%)
\$8,000-\$8,999	4 (3%)	0 (0%)
\$9,000-\$9,999	4 (3%)	0 (0%)
\$10,000-\$10,999	5 (4%)	0 (0%)
\$11,000-\$11,999	1 (1%)	2 (1%)
\$12,000+	13 (10%)	1 (1%)
Don't know	4 (3%)	3 (2%)
No answer	10 (8%)	4 (3%)
Total	126 (100%)	145 (100%)

Table 20: Years of education: waiting list and medical insurance respondents compared.

		Age education ended						total
		12 or less	13-15	16-18	19-21	22-24	25+	
wait-								
ing								
list	7 (5%)	72 (50%)	57 (39%)	4 (3%)	4 (3%)		1 (1%)	145 (100%)
medic-								
al								
insur-	2 (2%)	36 (29%)	60 (48%)	12 (10%)	5 (4%)	10 (8%)	1 (1%)	126 (100%)
ance.								

Table 21: Occupational prestige: waiting list and medical insurance respondents compared.<sup>15</sup>

		high ←———— occupational status —————→ low								
retired; 1 no occup- ation given.		2	3	4	5	6	7	other	total	
<hr/>										
wait- ing list	11 (8%)	1 (1%)	0 (0%)	13 (9%)	10 (7%)	41 (28%)	36 (25%)	22 (15%)	11 (8%)	145 (100%)
<hr/>										
medic- al insur- ance	13 (10%)	10 (8%)	14 (11%)	17 (13%)	21 (17%)	18 (14%)	22 (17%)	6 (5%)	5 (4%)	126 (100%)

Overwhelmingly, those on the waiting list who chose to "do something", chose exit. Thus 44 people, or 30% of those in the waiting list sample, reported that they planned to take out medical insurance, had already taken out medical

insurance, and/or planned to go to a private hospital for the treatment of their present medical problem. For convenience, I have called this group "leavers" and those remaining "stayers". (See Tables 22 and 23 below: note that in Table 23, 27 of the 41 people who had already taken out medical insurance, or who planned to, also intended going to a private hospital for the treatment of their present medical problem; thus they are leavers in a double sense).

Table 22: Distribution of exit choice in waiting list sample.

leavers	stayers*	total
44 (30%)	101 (70%)	145 (100%)

\*stayers include all of those (including don't knows and no answers) who did not positively report themselves as leavers.

Table 23: Distribution of leavers by kind.

have taken out medical insurance	plan to take out medical insurance	plan to use private hospitals but not take out medical insurance	total
17 (39%)	24 (55%)	3 (6%)	44 (100%)

In contrast few waiting list respondents made use of voice. Overall 6 of 101 stayers (6%) reported using voice to increase the supply of public sector care; no stayers planned to voice about supply in future (either because

it worked, or more likely considering that they were still waiting list respondents, because it was ineffective) (see Table 24 below).

Of the 6 instances of voice, only one even remotely involved political actors; the respondent supported a political party whose programme he believed to include improvement of the public sector. The other five instances involved people complaining to their doctors or hospital personnel (other than the board) and one person who just "complained".

As for the standard of care no stayers had made use of voice although two planned to; the first complaining to hospital personnel (other than the board) and the second to a source unspecified. (see Table 24 below).

Table 24: The incidence of voice among stayers..

aim of voice:	have or plan to voice.	no voice	don't know	no answer	total
to increase supply	6 (6%)	93 (92%)	0 (0%)	2 (2%)	101 (100%)
to improve standard	2 (2%)	99 (98%)	0 (0%)	0 (0%)	101 (100%)

Of the leavers, 5 of 44 (11%) reported using voice to improve supply (all by complaining to their doctor or hospital personnel (other than the board); like stayers, no leavers planned to voice about supply in future. (see Table 25 below). Only one leaver (who reported that he paid close attention to the candidates standing



for election to the hospital board), was coded as using voice to improve the standard of care.

Table 25: The incidence of voice among leavers .

Aim of voice:	have or plan to voice.	no voice	don't know	no answer	total
To increase supply	5 (11%)	39 (89%)	0 (0%)	0 (0%)	44 (100%)
To improve standard	1 (2%)	41 (93%)	0 (0%)	2 (5%)	44 (100%)

In all therefore, only 14 past or planned instances of voice were reported; 11 about supply (significantly no one planned to voice in future about this) and 3 about standard. 6 of the instances involved leavers whose lack of future plans for voice may suggest waning concern, while only 2 of the instances even remotely involved political actors (i.e. the possibility of collective benefits). Thus, those on the waiting list who wished to "do something" and apparently able to choose between voice and exit, overwhelmingly chose the latter.

#### THE WAITING LIST AS A CHOICE SITUATION: STAYERS AND VOICE.

But what about those for whom no choice was possible; those whose only option appears to be voice. Clearly stayers as a group have made little use of voice up until now and, at least in the crucial matter of supply,

plan none in the future. At the same time it is from dissatisfied stayers that the most voice might be expected; unlike either medical insurance respondents or leavers, stayers are the ones who can only remedy their dissatisfaction by voice. How is it that so little voice occurs?

Lack of voice is certainly not explained by an absence of dissatisfaction among stayers. Although the incidence of dissatisfaction is lower than among leavers (stayers as I argued in chapter 1 will include those who care little about quality, as well as those who are dissatisfied but unable to exit), it is still substantial; 43% of stayers report themselves dissatisfied with supply and 10% with the standard of public sector care. (See Tables 26 and 27 below).

Table 26: Responses of leavers and stayers to satisfaction with supply question, compared.

	fully satis- fied.	reason- ably satis- fied.	some what dis- satis- fied.	very dis- satis- fied	don't care	don't know	no answer	total
Stayers	11 (11%)	40 (40%)	30 (30%)	13 (13%)	4 (4%)	0 (0%)	3 (3%)	101 (100%)
Leavers	3 (7%)	11 (25%)	17 (39%)	10 (23%)	2 (5%)	0 (0%)	1 (2%)	44 (100%)

But still no voice. The simplest explanation is voice's intrinsically high cost; as I have shown it appears sufficient to effectively discourage respondents in both samples from its use. But as well, as I argued in Chapter 1,

those people who are dissatisfied but unable to exit, will find the use of voice more difficult than any other group. Not being able to exit is the outcome of having less resources than most others.

Table 27: Responses of leavers and stayers to satisfaction with standard question, compared.

	fully satis- fied	reason- ably satis- fied	some what dis- satis- fied	very dis- satis- fied	don't care	don't know	no answer	total
stayers	52 (51%)	25 (25%)	7 (7%)	3 (3%)	3 (3%)	4 (4%)	7 (7%)	101 (100%)
leavers	19 (43%)	19 (43%)	4 (9%)	2 (5%)	0 (0%)	0 (0%)	0 (0%)	44 (100%)

Three important political resources are education, income and occupational prestige. Leavers and the medically insured are better educated than dissatisfied stayers on average (although the difference between dissatisfied stayers and leavers is slight).<sup>16</sup> (See Table 28 below). As well leavers and the medically insured earn substantially more than dissatisfied stayers (Table 29 below) and are more likely to be found in more prestigious occupations (Table 30 below). Thus, of all of those who are, or have been anxious to "do something" to remedy their dissatisfaction with public sector deficiencies, dissatisfied stayers have the least voice resources. As well, exit works to drain off those in the waiting list set with more, rather than less, voice resources: it selects disproportionate numbers of those with

more education, more income, and higher occupational prestige.

Table 28: Mean years of education of dissatisfied stayers, leavers and the medically insured.

	Mean years	
dissatisfied stayers	15.05	(N = 43)
leavers	15.3	(N = 44)
medically insured	17.3	(N = 125)

Table 29: Mean income of dissatisfied stayers, leavers and the medically insured.

	Mean income	
dissatisfied stayers	\$4,134	(N = 41)
leavers	\$4,881	(N = 42)
medically insured	\$6,241	(N = 112)

Table 30: Occupational prestige of dissatisfied stayers, leavers and the medically insured

	high ←———— occupational prestige —————→ low				
	1 & 2	3 & 4	5 & 6	7	Total
dissatisfied stayers	0 (0%)	7 (20%)	20 (57%)	8 (23%)	35 (100%)
leavers	0 (0%)	8 (22%)	26 (71%)	3 (8%)	37 (100%)
medically insured	24 (22%)	38 (35%)	40 (37%)	6 (6%)	108 (100%)

But social scientists deal in probabilities; thus voice potential may vary widely between people with the same resources as well as between people with different resources. One important determinant of voice potential for any given level of resources is age. As I argued in Chapter 1, old people are likely to find exit more difficult than young; as well old people will find voice more difficult than young. The definition of an old person is difficult; many people are "old before their time" while the capabilities of others remain almost unimpaired until death (Bertrand Russell is perhaps the best example). Nevertheless, for most people reaching 70 can be considered a generous estimate of entering old age.<sup>17</sup>

Table 31 shows that the only people over the age of 69 in either group sampled are found among the stayers; 10% of all dissatisfied stayers are by this definition old people. As well, a comparison of the mean ages of leavers and stayers in Table 32 shows that exit works to drain off proportionately more young than old people from the waiting list set (just as it works to drain off higher rather than lower income people, those in more rather than less, prestigious occupations and (perhaps) those with more rather than less education). Dissatisfied stayers are thus doubly handicapped; they have less voice resources than others, and the ability of some stayers to use these resources is diminished by old age.<sup>18</sup>

The level of political energy in the stayers group also appears lower than in the other two groups (although the matter is less clear cut). As the Tables below show, dissatisfied stayers are less likely than others to report

themselves as opinion leaders (Table 36), less likely to belong to a voluntary association (Table 33) and, if they do, are likely to belong to fewer (Table 34) associations than others. They are less likely to have voted in local body or general elections (Table 33), to have gone to campaign meetings (Table 33), to belong to a political party, or (if they do belong) to be active in it (Tables 33 and 35). Stayers are about as likely as others to have contacted an M.P. (Table 33) but less likely to have contacted a Cabinet Minister, the Ombudsman or a lawyer (Table 33). Finally, stayers are less likely to have worked through an organisation, written to a newspaper or magazine or taken part in strikes or protests (Table 33).

Table 31: Age distribution of leavers, dissatisfied stayers and the medically insured.

	Years							
	18-19	20-29	30-39	40-49	50-59	60-69	69+	Total
dis- satis- fied stayers	1 (2%)	6 (14%)	11 (26%)	6 (14%)	10 (24%)	4 (10%)	4 (10%)	42 (100%)
leavers	1 (2%)	8 (18%)	13 (30%)	11 (25%)	8 (18%)	3 (7%)	0 (0%)	44 (100%)
medic- ally insured	0 (0%)	13 (10%)	24 (19%)	31 (25%)	33 (26%)	24 (19%)	0 (0%)	125 (100%)

Table 32: Mean ages of leavers, dissatisfied stayers and the medically insured compared

	Mean age	
dissatisfied stayers	46	(N = 42)
leavers	41	(N = 44)
medically insured	47	(N = 125)

Although some of the differences are small, each item that discriminates between stayers and the other two sets shows stayers as having less political energy. Again exit works differentially, selecting from the waiting list those who are most energetic. Thus, leavers belong more often to voluntary associations, and when they do, belong to more of them; while there are about the same proportion of political party members among leavers as among stayers, all of those who consider themselves active party members become leavers and so on.

Dissatisfied stayers anxious to "do something" wind up face to face with Catch 22. Voice is the only option they have to remedy their dissatisfaction; at the same time their lack of political resources and energy makes voice more difficult for them than for others. In such a situation I argued in Chapter 1, dissatisfied stayers will do exactly what they in fact plan to do : nothing.

Table 33: Political energy of dissatisfied stayers, leavers and the medically insured, compared.

Political Energy: Action taken	% Taking Action		
	dissatis- fied stayers	leavers	medically insured
Belong to a voluntary Association	70%(30)	91%(40)	75%(95)
Voted at local body elections	66%(27)	69%(29)	85%(102)
Voted at last general elections	93%(38)	98%(41)	94%(114)
Went to an election campaign meeting	21%(9)	34%(15)	30%(38)
Belong to a political party	14%(6)	16%(7)	21%(27)
Contacted an M.P.	12%(5)	11%(5)	13%(16)
Contacted a Cabinet Minister	5%(2)	7%(3)	9%(11)
Contacted the Ombudsman	0%(0)	2%(1)	2%(2)
Contacted a lawyer	26%(11)	39%(17)	37%(46)
Worked through an organisation	16%(7)	25%(11)	24%(30)
Written a letter to a newspaper	7%(3)	20%(9)	10%(12)
Been in a strike or protest	2%(1)	16%(7)	4%(5)

But this extended comparison between the energy and resources of leavers and stayers does more than simply explain why those who are dissatisfied, but cannot exit, remain passive. As well it suggests how for any given set of people (in this case those on the waiting list) exit works to select out those who otherwise could be expected to be voice's most active agents. Thus exit claims from



the waiting list a disproportionate share of those who have more rather than less political resources and energy.

Table 34: Mean number of voluntary associations belonged to by association members among dissatisfied stayers, leavers and the medically insured.

	Mean number	
dissatisfied stayers	1.79	(N = 29)
leavers	2.31	(N = 39)
medically insured	2.57	(N = 95)

Table 35: Degree of activity of political party members among dissatisfied stayers, leavers and the medically insured.

	How active a member				
	very active	active	fairly inactive	inactive	total
dissatisfied stayer	0 (0%)	0 (0%)	1 (17%)	5 (83%)	6 (100%)
leaver	2 (29%)	2 (29%)	1 (14%)	2 (29%)	7 (100%)
medically insured	3 (11%)	7 (26%)	17 (63%)	0 (0%)	27 (100%)

Table 36: Opinion leadership: How likely is respondent to be asked his opinion on political and social issues compared with his circle of friends?

	more likely	as likely	less likely	total
dissatisfied stayers	6 (14%)	22 (52%)	14 (33%)	42 (100%)
leavers	14 (33%)	18 (42%)	11 (26%)	43 (100%)
medically insured	35 (28%)	62 (49%)	27 (21%)	126 (100%)

#### SUMMARY OF THE WAITING LIST AS A CHOICE SITUATION.

Those on the waiting list who chose to "do something" to remedy their dissatisfaction with public sector care overwhelmingly chose exit; those who were dissatisfied but apparently unable to exit, planned to do nothing. As well for any set of people the exit process works to drain off those who might otherwise be voice's most active agents.

#### THE OVERALL INCIDENCE OF EXIT.

More people than waiting list leavers have been exiting. Southern Cross, the first and largest of the medical insurance societies (with about 80-85% of all of the medically insured on its lists) has grown from less than 1,000 members in 1961 to almost 300,000 members at the end of 1973. Each year its membership has increased by roughly half.<sup>19</sup>

Two other societies, the New Zealand Medicare Society and the Group Medicare Co-operative Society (both founded

in October 1971) also provide medical insurance. Both had grown to between 20,000 and 30,000 members each by the end of 1973, their membership doubling or more each of their two years of operation.<sup>20</sup> In addition a new society, the Mutual Health Society Ltd, is being planned to cater for the needs of trade union members; unlike the existing societies it will offer in addition to the usual benefits regular income related payments covering sickness periods. (A fourth Company, Manchester Unity, operated from 1968 until the beginning of 1973 at which time its members were largely incorporated into the Southern Cross scheme). Overall, the growth in the numbers of people with medical insurance has been exponential; not only has the number of those insured rapidly increased, but the rate of this increase has itself increased.

The records of traditional welfare societies provide further evidence of the increasing use of exit. Friendly Societies, such as the Hibernian Society and the five State Service Welfare Societies, pay rebates to members making use of private hospitals (in the former case the subsidy is nominal). Of these organisations, two, the Post Office Welfare Society and the Public Service Welfare Society, keep records allowing the identification of rebates on private hospital fees (the records of the other organisations lump all "medical" payments together). In both cases (see Table 37 below) there is an increase in the numbers seeking rebates; for the Post Office Welfare society the same exponential increase as was observed for the growth of medical insurance occurs.

Table 37: Private hospital claims: Post office and public service welfare society.

Year	No. of claims	
	Post Office	Public Service
1962	324	-
1963	429	-
1964	462	-
1965	609	-
1966	687	-
1967	729	-
1968	843	-
1969	894	-
1970	951	0
1971	1391	0
1972	2157	151
1973	-	-

Nevertheless actual use of private hospitals has increased at a rate considerably slower than the growth of medical insurance (see Table 38). Surgical admissions increased from 40,125 for the period March 1970 to March 1971, to 44,601 at March 1972, and 51,792 at March 1973, representing increases of 11% and 16% respectively. (Note that the data, although insufficient to reliably reveal any trends, is consistent with exponential growth).

There are at least three possible explanations of the

"lag" between the growth of medical insurance and the increasing demand for private hospital care. The first and simplest, is that the private sector is unable to satisfy rapidly increasing demand; thus the use of private hospitals has not increased because the private sector is presently unable to accomodate any more patients. There is however no evidence of unsatisfied demand for private sector services that I know of; certainly no waiting lists comparable to those for public sector services occur. In addition, there is considerable evidence that a large amount of "slack" exists in private hospital operations: i.e. that without new facilities or resources the private sector can cope with rapid increases in demand. Thus for example, private hospitals in Auckland without any increase in facilities were able to cope with 5,419 (37%) more surgical admissions in 1972-1973 than in 1971-1972 (see Table 38 below).

A second possible explanation is that the population taking out medical insurance and the population who normally use private hospitals are pretty much the same. Thus there has been little increase in the use of private hospitals because the same people, many now insured, are still making the same use of the private sector.

Such an argument is not necessarily inconsistent with the previously presented facts that 20% or more of those with medical insurance could not use private hospitals without it, and that an increasing number of members of welfare societies, who have not previously done so, are making use of the private sector. It is, however, clearly inconsistent with the 37% increase in surgical admissions

in Auckland in 1972-1973 (unless I am to believe that, for no apparent reason, the incidence of medical problems among the pool of private hospital users increased dramatically in that year).

A third explanation, that, for several reasons, it takes some time for an expansion in the numbers with medical insurance to result in a similar expansion in demand for private hospital care, is the only explanation that appears to adequately fit all of the facts available. On this explanation the reasons for the "lag" are twofold: first, because the growth in the sale of medical insurance has been exponential, most of those insured have been signed up in the last one or two years. Second, because of the policies adhered to by the medical insurance societies only healthy people can sign up, and even these people are not usually covered for any pre-existing conditions or condition that arise in the first three months after taking out a policy. Thus I expect the impact of medical insurance on private hospital use to be considerably delayed.

Such an explanation makes sense of the apparently inconsistent facts, that a large number of the medically insured are apparently drawn from outside the pool of traditional private hospital users, and yet the increase in the actual use of private hospitals has been relatively slow. It suggests that a rapid increase in demand for private sector services will occur, but not right away. The fact that medical insurance has been sold earliest and most heavily in Auckland of all the main centres is consistent with the sudden rise in private hospital surgical admissions in the city. Thus, in this view, the Auckland figures reflect

what will soon occur elsewhere as the medically insured increasingly develop conditions requiring surgical remedy.

Table 38: Surgical Admissions to private hospitals by health district\*

Health district	No. of surgical admissions		
	Year ending 31-3-71	Year ending 31-3-72	Year ending 31-3-73
Whangarei	391	457	551
Auckland	13,168	14,662	20,081
Hamilton	4,801	5,171	5,087
Rotorua	1,966	2,083	2,826
Gisborne	609	521	409
Napier	629	714	957
New Plymouth	1,058	1,158	1,242
Wanganui	701	957	991
Palmerston North	1,516	2,636	2,459
Wellington	4,819	5,253	5,903
Nelson	641	637	861
Christchurch	6,010	6,570	7,049
Timaru	417	474	401
Dunedin	1,628	1,705	1,814
Invercargill	1,701	1,603	1,661
Total	40,125	44,601	51,792

Source: figures supplied by Department of Health.

#### SUMMARY.

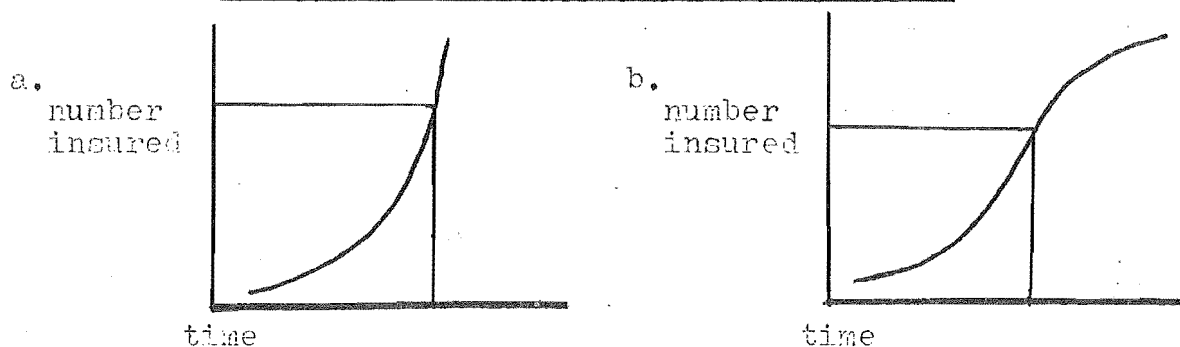
People are exiting at an exponentially increasing rate from the public sector; of the 11% or so of the population now covered by medical insurance more than half have exited since the beginning of 1972. There is evidence that the

translation of the growth of medical insurance into rapidly increasing demand for private hospital care has already begun.

#### THE FUTURE INCIDENCE OF EXIT.

Given a finite population, exponential curves such as the one plotted for the diffusion of medical insurance are most accurately seen as the middle section of the familiar S-shaped logistic curve (see figure 1 below). Thus linear projections based on present growth will likely be in error because the slope of the diffusion curve will continue to change. Of particular interest in the present discussion is the possibility that the diffusion curve for medical insurance is likely to flatten out in the next few years; i.e. that the numbers of people with medical insurance are unlikely to increase much more.

Figure 1: Diffusion curves for medical insurance.



- a. exponential curve for diffusion of medical insurance.
- b. same curve fitted as part of logistic curve.

Such a possibility seems most unlikely. First, evidence from other somewhat similar societies, in particular the United States and Australia shows that it is possible



for 80% or more of population to have medical insurance; thus the potential for selling medical insurance in New Zealand is still largely untapped.

Second, it appears that a considerable number of those presently making use of private hospitals are as yet uninsured; i.e. the market for medical insurance among present private hospital users is far from saturated.<sup>21</sup> In addition the overall cheapness of premiums, the continuing expansion of company subsidised schemes and the development of trade union schemes means that exit is likely to become even easier in future.

Finally because (as I show in the next chapter) exit creates consequences likely to further increase the incidence of dissatisfaction with the public sector, more and more people will have reason to exit. Overall, it appears that the incidence of exit will continue to increase in the next few years.

However it may be that the private sector is unable to cope with further increases in demand, thus making exit impossible. Again such a possibility seems most unlikely. I have already argued that there is a good deal of "slack" in the private sector; thus it is probable that private hospitals could cope with many more patients than they do at present. As for further expansion, the encouragement of "trust" control in the private sector means that expansion may be undertaken as a public service, even if it is likely to be only marginally (or not at all) profitable. The "insulation" of the consumer from increases in the costs of private hospital care provided by medical insurance means that fees can be raised to finance expansion with

113  
little chance of alienating custom.<sup>22</sup> Finally, for reasons that I will outline in detail in the next chapter, it is likely that the expansion of the private sector will be heavily financed by public funds.

#### SUMMARY.

In the next few years the growth of exit is likely to continue at the same or at an even faster rate. This growth will be accompanied by the further expansion of the private sector.

#### THE OVERALL INCIDENCE OF VOICE: EVIDENCE FROM THE SURVEY.

In contrast to the extensive use of exit it appears that little voice has occurred or is likely to occur. I have already shown how few waiting list respondents made use of voice, and how even fewer planned to do so in future. In particular only one person's use of voice involved (construed in the broadest sense) political actors (see Tables 24 and 25 above).

Even less voice was reported by the medically insured. Only three people (2%) had used voice to increase the supply of medical care (see Table 39 below). Of these, two had sometime previously complained to their doctor or hospital personnel (other than the board) about inadequate supply; neither had any plans to voice in future. The third respondent had in the past worked through the National party, as an active member of the local electorate organisation (amongst other things) to try to improve the supply of hospital care and planned to do so again in the future.

(although not currently an active party member). The same respondent was the only person in the medical insurance sample who reported that he had previously or in future planned to use voice to improve the standard of public sector care, again by working through a political party (see Table 39 below).

Table 39: The incidence of voice among medical insurance respondents.

Aim of voice	have or plan to voice	no voice	don't know	no answer	total
To increase supply	3 (2%)	116 (92%)	0 (0%)	7 (6%)	126 (100%)
To improve standard	1 (1%)	113 (90%)	0 (0%)	12 (10%)	126 (100%)

Thus, while dissatisfaction with public sector care led the medically insured to exit, only in three cases did it also result in voice. It also appears that having exited, future voice is unlikely; only one respondent reporting that he planned to make further use of voice. This single deviant case fits neatly into the category "ideologue". As a previously active National Party member (who had tried to change the party's Vietnam policy and marched in public demonstrations on the war), the respondent justified his resort to voice in terms of a doctrine of a good society and the connection of first rate public sector care with such a society. Thus the incidence of voice among those sampled has been low and may be even lower in future.

# THE INCIDENCE OF VOICE: EVIDENCE FROM VOICE COLLECTION POINTS.

Hospital board members are charged with representing the community in the provision of hospital care. Accordingly I wrote to members asking them how many, if any, complaints they received about public sector care and what these complaints were about. Eleven of the fourteen members replied. From Table 40 below, it is clear that, overall, members receive few complaints; on average about fifty a year, of which approximately twenty four are received by one board member. Information from the board's chairman suggested that letters of complaint,

are more often addressed either to the Chief Executive or to the Medical Superintendent-in-Chief, which is of course the correct procedure. Such complaints I doubt would number as many as one per month.<sup>23</sup>

It is clear that neither the board nor its officers are besieged by voice.

Table 40: Number of complaints received by hospital board members.

	Number or complaints per year					total not clear	total respond- ents
	Less than 1	1-3	4-6	7-9	9+		
No. of respond- ents receiving complaints	1	3	2	1	1	3	11

Three of those replying commented on the reluctance of their constituents to give particulars of their grievances and presumably, to make complaints at all. One member (who received by far the largest number of complaints) reported that people waited four to ten months before lodging a complaint; she noted,

Most are reluctant to register their complaint for fear of "whiplash" should they require further hospital care or are so grateful for small mercies that they prefer to suffer in silence when nurses seem rushed off their feet. The less affluent and articulate appear to fear the Medical Profession more than they fear God. As well the majority of my complainants do not wish their names divulged but eventually speak up in the hope that as a board member I may be able to spare others from suffering the same fate.<sup>24</sup>

Complaints to board members covered a number of topics; the most common (in terms of numbers of members reporting it) was the waiting list.

Similarly members of parliament with electorates in North Canterbury have received few complaints about public sector care. All ten members agree that the percentage of complaints concerning public sector care is a very low proportion of the total constituent problems they deal with; the highest figure reported is 4% of all problems (compared with, for the same member, 60% for housing). Three of the ten members (including two out of the three National party members in the region) report receiving no complaints at all in the last year. The most common source of complaint is again waiting time in getting into a public hospital.

In absolute terms it appears that members of parliament handle a bigger volume of complaints about the public

sector than hospital board members. However, relative to the total number of complaints they deal with, the number concerned with public sector care is very low. Again there is no evidence of even a moderate outburst of voice.

A third place I looked for evidence of voice was the Letters to the Editor columns of the Christchurch Star and the Christchurch Press. The results of a content analysis of those letters dealing with hospital care for the year September 1 1972 to August 31 1973, is set out in Table 41.

Table 41: Topics of letters to the editor dealing with hospital care.

No.	% all letters on hospital care.
23	(50%) letters protesting the closing of Marylands.*
3	(7%) letters in praise of the benefits brought by private hospitals
5	(11%) letters dealing with nurses' training and conditions
3	(7%) letters dealing with patients' right to smoke
3	(7%) letters dealing with inadequacies in medical facilities at public hospitals (including personnel)
2	(4%) letters arguing that the National or Labour party poorly handled the Health portfolio
2	(4%) letters of praise for good care received at public
2	(4%) inquiries whether victims of accidents had to pay their own public hospital bills
2	(4%) complaints about car noise outside Christchurch Women's Hospital
1	(2%) letter inquiring about the access of private hospital patients to public hospital facilities
46	(100%) total (31 in <u>The Press</u> ; 15 in the <u>Christchurch Star</u> .)

\*Marylands is a residential home for the intellectually handicapped run by the Catholic Church. Because of lack of funds it threatened to close up; however after considerable voice the government agreed to provide it with a grant sufficient for its work to continue.

The most important point to be gleaned from the Table is the complete absence of complaints about long waiting times for public sector care, the grievance most often mentioned by those interviewed (note however, three complaints criticising the quality of public sector care). As well, adding together the letters on Marylands and the letters in praise of private hospitals, 57% of all letters to the editor for the year were written in support or praise of the private sector.

Other traces of voice are equally difficult to discover. The 1973 Labour Party Conference dealt with a resolution condemning the spread of medical insurance; a few people (all of whom fit neatly into the category ideologue) have presented submissions to government inquiries pointing out the poor state of public sector services and arguing against the further expansion of the private sector.<sup>25</sup> In two cases (Dr Sutch and the F.S.A.) these submissions have been published, in both cases resulting in little public comment.

#### SUMMARY.

Again the evidence suggests that the incidence of voice about public sector care is extremely low. Again, what voice does occur, at least inasmuch as it finds its way into the public record, appears to stem from ideologues.

#### THE FUTURE OF VOICE.

It is likely that less, rather than more voice will occur in future. Of those people in the sample who had made

use of voice only one, an ideologue, planned to continue its use. Presumably ideologues in general (who care not only about the hospital services they personally receive but also about the arrangements through which medical care is distributed) will continue to voice. However the exponential increase in the use of exit ever more quickly deprives them of a potential audience, a point dealt with more fully in the next chapter.

THE EXPECTED EXCEPTION: WHERE EXIT IS NOT AVAILABLE TO ANYONE.

The possibility of exit as a remedy for dissatisfaction depends on the ready availability of private sector facilities; facilities which are non-existent in many smaller New Zealand cities and provincial towns. My argument suggests that dissatisfaction in such places will result in voice (except of course in the unlikely situation that voice is too costly for anyone to make use of it).

My own observations suggest that with one exception (to be discussed later) little voice has issued from such centres; either no one is dissatisfied (the absence of voice does not contradict my argument) or people are dissatisfied, voice is within their reach, but for some reason is not used, (my argument is contradicted).

Fortunately for the development of confidence in the central argument, there is good reason to believe that the first explanation applies; i.e. that people in such centres are likely to be satisfied with the provision of public sector care. Because it fits there more neatly, I present



the evidence bearing on this point in the next chapter.

#### CHAPTER SUMMARY.

The evidence presented supports the following contentions:

1. A great many New Zealanders are dissatisfied with public sector care; in particular with its inadequate supply.
2. Where exit is available, those dissatisfied overwhelmingly choose it rather than voice to remedy their dissatisfaction, while those who find its use difficult are still unlikely to voice.

The consequences of this choice are explored in Chapter 4.

## NOTES.

<sup>1</sup>The New Zealand Woman's Weekly, November 19, 1973.

<sup>2</sup>New Zealand Herald, December 14, 1973.

<sup>3</sup>Robert A. Dahl, Who Governs (New Haven: Yale University Press, 1961), pp.223-225.

<sup>4</sup>It is clear also that a number of those interviewed regard medical insurance as a relatively "cheap" means of escaping the public sector; 20% and 18% of respondents mentioning the tax exemption and savings on medical bills respectively.

<sup>5</sup>The discrepancy that arises from using two different kinds of questions to find out how important is, "choice of surgeon", nicely illustrates the point that the survey instrument is not unobtrusive, and that respondents' memories are changeable.

<sup>6</sup>See Appendix 4.

<sup>7</sup>Coded as "personal impotence" were statements like: "one person can't do much"; "no one would listen to people like me"; "there's nothing I could do", "its up to the doctors", and so on. Coded as "constrained by situation" were statements like: "there's a staff shortage; no one can do anything about that", "there's just not enough beds", and so on.

<sup>8</sup>Costs are taken from an advertising pamphlet, copyright Southern Cross Medical Society 1972. They may well be higher now.

<sup>9</sup>New Zealand Consultative Committee on Hospital Reform. Report. and Private Hospitals in New Zealand.

<sup>10</sup>The Press, January 26, 1974.

<sup>11</sup>For Sutch's argument see, W.B. Sutch, The Responsible Society in New Zealand, (Christchurch: Whitcombe and Tombs Ltd., 1971); and for the P.S.A. argument, Public Service Association Inc., P.S.A. Newsletter, 19 (1973).

<sup>12</sup>A.O. Hirschman, Exit Voice and Loyalty, p.43.

<sup>13</sup>Being on the waiting list indicates the existence of a known medical condition requiring treatment; medical insurance companies will not pay out to members suffering

from conditions occurring before membership; thus taking out medical insurance provides for future but not present incapacities. There is good reason to believe that most people found on the waiting list could only afford private hospital care, if at all, with the help of medical insurance (see Table 19).

- 14 Of course the difficulty people have in affording premiums given a certain income level, will vary a great deal. Thus people on a small income but with a house paid for and no children left at home, may quite easily afford premiums, while another couple, paying off a mortgage and bringing up children may be poor in every sense of the word, and quite unable to afford premiums. Nevertheless gross income provides a rough enough guide to capacity to pay in the present circumstances.
- 15 The Occupational Prestige Ranking Scale used is an adaption of Congalton's 7-point 'Status Ranking of Occupations in Australia' (1969) formulated by Mr Peter Davis, Department of Psychology and Sociology, University of Canterbury. Those occupations with the highest prestige fall into category 1; those with the lowest into category 7.
- 16 The category "dissatisfied stayer" is made up of all of those stayers who report themselves dissatisfied with the supply of public sector care.
- 17 I would have preferred to define "old people" as those over the age of 65: i.e. when people retire, losing in the case of men their ties to workplace and usually a good deal of their income. Unfortunately the survey category coded ran from 60-69.
- 18 Note that the mean age of those with medical insurance is higher than the mean for leavers or stayers. What is important here is not the differences in the mean ages between the two sample sets (those in the waiting list and the medically insured) but the fact that for a given set (the waiting list), exit tends to select out those with more rather than less voice resources. As well age is important as a predictor of the capability of using political resources only at its extremes; thus it is old people and children who have difficulty. There is likely to be little difference between a 25 year old and 50 year old person in their ability to use resources available to them (in fact experience may be a benefit).
- 19 Mr L.H.I. Watson, "Report to the Annual General Meeting of the Southern Cross Medical Care Society", The Press, April 13, 1974.
- 20 The information is from letters to me from D.T. Mills Executive Director of New Zealand Medi-care Society (11 September, 1973) and G.D. Wrigley, Secretary Group Medi-

care Co-operative Society (6 September, 1973).

<sup>21</sup> Southern Cross report a survey of 650 surgical cases at five of Auckland's private hospitals; of these 220 (or 33.8%) were covered by voluntary health insurance. Southern Cross Medical Care Society, "Submissions" p.2.

<sup>22</sup> See, Joseph P. Newhouse and Vincent Taylor, "The Subsidy Problem in Hospital Insurance; A Proposal", Journal of Business, 43. (1970) 452-456.

<sup>23</sup> Letter to me from Dr L.C.L. Averill, September 4, 1973.

<sup>24</sup> Letter to me from Mrs M.M. Clark, February 6, 1974.

<sup>25</sup> The New Zealand Labour Party, "Report of the 57th Annual Conference", (mimeo, 1973).

CHAPTER 4: CONSEQUENCES OF EXIT AND VOICE

In this chapter evidence for two principal contentions is presented; first, that exit, unlike voice, stimulates no one to repair public sector lapses; second that exit, again unlike voice, works to deprive the public sector of the resources necessary for its recovery, thus setting in motion a cycle in which public sector services progressively deteriorate.

#### EXIT AND THE REPAIR OF PUBLIC SECTOR LAPSES

Despite the partial "socialization" of medicine, the members of the New Zealand medical profession continue to exercise a great deal of control over the provision of medical care. No government, no matter how great its mandate, has attempted to implement any change in medical care policy without prior consultation with the profession's representatives. Whenever the views of government and the profession have conflicted, the profession has been consistently successful in winning substantial concessions from government.<sup>1</sup>

In addition, individual doctors have a large amount of control over the organisation and management of medical care, by virtue of their monopoly of "clinical" decisions (i.e. those apparently requiring the use of medical expertise, of which by definition, doctors have the most). Thus within hospitals it is up to a doctor to determine how long the patient should stay, how he should be treated and so on.

If exit in anyway threatened their livelihoods, or offended against finer sentiments, doctors are clearly in a powerful position to halt it. But, at least for livelihood,

the opposite is true; for the reasons set out in Chapter 1, the greater the incidence of exit, the richer (and perhaps the happier) many hospital specialists become.

In fact, the medical profession has not used its strategic position to end exit. Instead it has sought to preserve the right of exit and encourage government subsidy of it. As the opening sentences of the profession's submissions to the Board of Health Committee on Private Hospitals state:

M.A.N.Z. wishes to stress the importance of continuing a dual method of Medical Service for the Country, both Private and Public.<sup>2</sup>

The submission continues to argue the case for further government subsidy of exit: three out of the five recommendations made involve increasing government subsidy of exit.<sup>3</sup>

Exit also fails to encourage doctors to make more efficient use of the public sector. Hernia and varicose vein cases together account for a large proportion of the total general surgery waiting list; they are also conditions extensively treated in the private sector. But in Auckland (where the volume of exit is greatest) increases in the rate of exit have not resulted in greater public sector efficiency in their treatment. Instead, for the five years 1965 to 1970, public sector efficiency (as measured by average days stayed by sufferers) in the treatment of varicose veins actually declined by 1.4 days (or 11%) (See Tables 42 and 43 below). At the same time,

public sector efficiency in the treatment of hernia increased only marginally from 1965-70 (0.4 days or 4 %).<sup>4</sup> The much greater efficiency achieved by doctors dealing with the same conditions in the private sector makes it clear that the public sector works considerably below capacity (See Tables 42 and 43).<sup>5</sup> Overall, exit does not appear to encourage doctors, either individually or collectively to use their strategic positions to bring about improved performance by the public sector.

Table 42: Average day stay for varicose veins: Auckland public and private hospitals 1955-72.

Hospital	Mean Number of Days				
	1955	1960	1965	1970	1972
Public	19.5	14.7	13.1	14.5	-
Private	-	-	-	-	6.0

Adapted from information in G.L. Salmond and E.M. O'Connor "General Surgical Waiting Lists and the Management of Varicose Veins".<sup>6</sup>



Table 43: Average day stay for abdominal hernia: Auckland public and private hospitals 1955-72.

Hospital	Mean Number of days				
	1955	1960	1965	1970	1972
Public	13.5	11.0	9.6	9.2	-
Private	-	-	-	-	6.3

Adapted from information in G.L. Salmond and E.M. O'Connor "General Surgical Waiting Lists and the Management of Varicose Veins".

Exit is no more effective as a stimulus to the efforts of hospital board members. In chapter 1, I argued that, for a variety of reasons, hospital board members were far more likely to welcome, than be alarmed by, exit.<sup>7</sup> In the course of my research I wrote to each of the fourteen North Canterbury Hospital Board members asking whether they saw a conflict between the public and private sectors, whether they would like to see it made easier, or more difficult, for people to exit and how they felt about the present rapid growth in the numbers of people with medical insurance.<sup>8</sup> The eight replies I received are set out in Table 44 below.

Table 44: Attitudes of hospital board members to exit.


---

Conflict exists between public and private hospitals?

yes	no	neither	total
1	7	0	8

---

Use of private hospitals should be made easier or harder?

easier	harder	neither	total
2	1	5	8

---

Favour or against the growth of medical insurance?

favour	against	neither	total
5	3	0	8

---

With one exception, board members replying see no conflict between the public and private sectors and would not like to see entry to the private sector made more difficult. They favour, five to three, the further growth of medical insurance. There is no evidence then to support the view that board members are alarmed by exit, or that it provides them with a pressing incentive to seek repairs to the public sector.<sup>9</sup>

Finally exit has failed to stimulate government action to repair the public sector. The present dominance of doctors sharply reduces the number of ways of improving the public sector available to government (short of a

thorough-going reorganisation of hospital services). Most importantly, decisions about the disposition and utilisation of facilities within hospitals remain largely in the hands of individual doctors. Thus, governments anxious to bring about the more efficient use of facilities within hospitals can at present do little more than admonish the public sector to achieve greater efficiency. The Hon. R.J. Tizard, the present Minister of Health, nicely illustrated the point in his address to the Medical Association of New Zealand, 12 June, 1973:

I am convinced however, that, as in any other large scale organisation, improved management technique will assist in reducing the size of waiting lists, provided there is the will and determination among all staff associated with patient care to seek better methods of management and put them into effect.

I am not referring to the professional care of a patient in relation to his treatment. Rather I am referring to the means by which care is delivered to the patient, and the optimum usage of hospital facilities and beds. The active co-operation of the medical profession both inside and outside the hospital is very necessary for these aims to be accomplished. <sup>10</sup>

However governments retain direct control over the overall allocation of resources to the public sector and in particular over the provision of additional public hospital beds. Unable to directly affect the efficiency with which these beds are used, governments can, nevertheless, seek to increase the number of beds to the point where their inefficient use matters little.<sup>11</sup> Additionally, the provision of new beds serves as a tangible reminder to constituents that, in their locality, the government has acted decisively to bolster the public sector. Thus

building additional beds may not only be politically attractive, but is also one of the few ways that government can improve public sector performance, barring major reorganisation.<sup>12</sup> The resort to the use of this option by government is at the root of the frequently heard complaint that government has "an edifice complex" or indulges in "political hospital building".

From this argument it follows that governments anxious to take, and be seen to take, action to improve the public sector will seek to increase the number of public sector beds available. Thus, if exit stimulates governments to improve the public sector, then the more exit, the more public sector beds government should provide. In fact the opposite is true. As Table 45 shows, the more exit per head of population (exit is calculated according to the number of surgical admissions to private hospitals) the lower the number of public sector beds per head of population. (Note, health districts are arranged in Table 45 by the number of public hospital beds per 1,000: thus Auckland with the fewest beds is at the top, and Gisborne, with the most, at the bottom).<sup>13</sup>

The circumstances surrounding the setting up of the Royal Commission to Inquire Into and Report Upon Hospital and Related Matters provides further evidence of the failure of exit to stimulate government action. The Commission, now disbanded, constituted the only major review of government policy on hospital services attempted for more than a decade.<sup>14</sup>

Table 45: Rate of Exit and the Provision of Public Hospital Beds

Health District	Number public hospital beds per 1,000 people 1972	Exit as percentage of population 1972
Auckland	4.3	2.8
Christchurch	4.7	2.2
Wellington	5.7	1.8
Hamilton & Rotorua	6.2	2.5
Palmerston North	6.4	2.1
Nelson	6.8	1.5
Invercargill	6.9	1.5
Dunedin	7.2	1.4
New Plymouth	7.3	1.3
Napier	7.3	0.9
Wanganui	7.5	1.3
Timaru	8.3	0.7
Whangarei	8.7	0.6
Gisborne	9.8	1.0

Its establishment was prompted, not by exit, but by voice; in this case discontent with government policy on psychiatric hospitals (which culminated in strike action in 1971) felt by psychiatric and psychopaedic nurses. While the Commission's terms of reference gave it a warrant to inquire into and report on most aspects of hospital services in New Zealand, no mention is made of exit.<sup>15</sup> In addition, the time-table set out for the Commission makes it clear that the impetus for the Commission was the "unrest in psychiatric hospitals".<sup>16</sup> Thus the Commission was required to report to the Government:

1. Not later than the 31st day of December your findings and opinions on the matters in clause 9 of the aforesaid terms of reference; [Clause 9 deals with the question of psychiatric and psychopaedic pay scales.]
2. Not later than the 30th day of June 1973 your findings and opinions on the matters aforesaid so far as they relate to psychiatric services;
3. Not later than the 30th day of June 1974 your findings and opinions on the other matters aforesaid.<sup>17</sup>

Additional evidence for the importance of voice (stemming from dissatisfaction with psychiatric, not general hospital services) in the setting up of the Royal Commission is provided in a letter from the then Minister of Health, the Hon. L.R. Adams-Schneider. He writes:

The main reason for the establishment of the Royal Commission to Inquire Into and Report upon Hospital and Related Services in New Zealand, revolved around the problems associated with the increasing pressures on our hospital services in recent years and the considerable changes which were in the process of

being put into effect, such as the shifting of the control of psychiatric hospitals from the Health Department to Hospital Boards.

This involved a considerable upheaval for staff at all levels and it also brought into its concept the desirability of introducing more psychiatric services in general hospitals; the scaling down of the number of psychiatric patients in the larger institutions, and the development of much more "community" treatment for psychiatric cases.

In addition, a considerable amount of controversy amongst hospital boards and related agencies concerning the administration and financing of hospital services had become evident...

As far as the staff unrest in psychiatric hospitals was concerned; in all fairness I certainly felt this played some part in the timing of the setting up of the Royal Commission but quite apart from this, it had become evident over the years that such an enquiry was desirable, having regard to the facts I have mentioned above. 18

Together the Minister's account of how and why the Commission was formed and the terms of reference and the time-table for the Commission point to two conclusions. First, the fact of rapidly accelerating exit raised no questions about the condition of the public sector, nor did it in any way lead to the setting up of the Commission. Second, the fact that the Commission was established in 1972, rather than before or after, was associated with the use of "voice" by psychiatric staff. Similarly, that the Commission's attention (at least in the short run) was focussed on the problems of psychiatric hospitals, is again attributable to the successful use of "voice".

But the argument advanced in Chapter 1, is not simply that exit fails to stimulate government attempts at repair; rather that governments, regardless of ideology, have reason to actively encourage exit as an alternative to repair.

There is an abundance of evidence to support this contention.

Since the Hospitals Act of 1957 it has been the duty of the Minister of Health

to encourage the provision and maintenance, to such extent as he considers necessary, of private hospitals within the meaning of Part V of this Act.<sup>19</sup>

However, Government aid to the private sector began well before the passing of the Hospitals Act. A private hospital loan scheme (the terms of which have been increasingly liberalised) was begun by the National government in 1952.<sup>20</sup> Since then both National and Labour governments have used the scheme to subsidise the expansion and renovation of the private sector. The total amounts paid out each year under the scheme are shown in Table 46.

Table 46: Money paid out each year under government loan schemes: 1952-1973.

Year	Amount	Year	Amount
1952-59	\$947,448	1966-67	\$37,820
1959-60	\$167,284	1967-68	\$30,630
1960-61	\$225,098	1968-69	\$300,043
1961-62	\$192,302	1969-70	\$446,444
1962-63	\$315,398	1970-71	\$801,405
1963-64	\$188,142	1971-72	\$390,105
1964-65	\$307,444	1972-73	\$378,859
1965-66	\$122,814	<u>Total</u> <u>1952-73</u>	<u>\$4,851,236</u>

Source: information supplied by Department of Health.



As interesting as the total amount of loan money provided, is its distribution. The criteria for allocating loan money is "need":

...every application for a private hospital loan is examined on the basis of all available public and private beds and facilities in the area, plus known proposals, and only when the "need" is justified, is support given to the loan application. <sup>21</sup>

As a consequence (See Table 47) loans tend to go to those areas where the public sector is least adequate (as a rough and ready measure of adequacy I have used the number of public hospital beds per thousand as of 1972).<sup>22</sup> Thus Auckland, Wellington and Christchurch which have the three lowest public bed to population ratio have received almost 70% of the total loan money available; Auckland with the worst bed ratio winning the greatest share, Wellington with the third worst bed ratio the second greatest share and so on. Thus governments, (both National and Labour) have done most to bolster the private sector in those areas where the public sector is least adequate.

Governments provide further subsidies to the private sector in the form of patient benefits (paid on a daily basis for each category of patient accommodated in a private hospital). Originally patient benefits were part of the package deal assembled by the first Labour Government to buy the medical profession's acquiescence to its health policy. Since then (see Tables 48 and 49 below) the subsidy rate and the total amount paid out has steadily increased.

Table 47: Allocation of Loan money by Health District  
1952-73.

Health District	Total loan money paid 1952-1973	% share of loan money	No. public beds per 1,000 people 1972*
Auckland	\$1,532,219	32%	4.3
Wellington	\$1,431,120	30%	5.7
Dunedin	\$605,926	12%	7.2
Christchurch	\$356,162	7%	4.7
Hamilton	\$281,084	6%	6.2
Napier	\$221,121	5%	7.3
other	\$423,604	9%	7.7(mean)
Areas getting no loan money	-	-	10.2(mean)

Source: information supplied by Department of Health

\*Note that the beds per thousand figure is for the hospital district as a whole, rather than just the centre to which loan money has been allocated.

Those making use of private hospitals also benefit from government subsidies in less visible ways. Drugs, for example, are provided free of charge, the cost of laboratory services is met almost entirely by the state, and so on.<sup>23</sup>

Finally, government subsidises payments made for medical insurance. An amendment to the Land and Income Tax Act passed in 1967, makes contributions for private medical insurance schemes tax deductible. In addition,

the then National government gave considerable symbolic encouragement to the fledgling medical insurance industry; several National party Cabinet Ministers (including the Minister of Health) personally welcomed the ten thousandth, fifty and one hundred thousandth member to the Southern Cross scheme.

Table 48: Daily patient benefit paid to private hospitals 1939-1973

Date	Surgical Patients	Medical and Convalescent Patients
1939	60c	60c
1943	90c	90c
1950	90c + subsidy of 60c	90c + subsidy of 45c
1951	90c + subsidy of 67.5c	90c + subsidy of 52.5c
1953	90c + subsidy of 99.16c	90c + subsidy of 84.16c
1954	\$2.10	\$1.80
1956	\$2.20 + subsidy of 25c	\$1.80 + subsidy of 25c
1958	\$2.50	\$2.05
1959	\$2.50 + subsidy of 30c	\$2.05 + subsidy of 15c
1961	\$2.80	\$2.20
1963	\$4.00	\$2.80
1.4.1965	\$5.00	\$3.50
1.8.1966	\$5.90	\$4.00
1.10.1969	\$7.40	\$4.50
1.11.1971	\$9.00	\$5.50

Source: Private Hospitals in New Zealand p.30.

Table 49: Total amounts paid in patients benefits 1963-1973.

Year	Payment \$	Year	Payment \$
1963/64	2,410,660	1968/69	4,139,561
1964/65	2,604,948	1969/70	4,590,359
1965/66	3,324,452	1970/71	5,290,965
1966/67	3,776,284	1971/72	5,915,224
1967/68	4,027,046	1972/73	7,015,604

Source: Private Hospitals in New Zealand p.31.

The actions of the present Labour government provide a crucial test of my argument that the logic of vote winning makes it likely that governments will subsidise exit, irrespective of their ideology.<sup>24</sup> After all, it has always been National Party policy to extend "freedom of choice" in medical care (i.e. subsidise exit) and the actions of the National government in the last decade could as well have been predicted knowing this fact alone.<sup>25</sup>

At first sight Labour's actions do appear to contradict my argument. In particular, the Labour government's refusal to accept a number of key recommendations made by the Board of Health Committee on Private Hospitals has led to the suggestion that the government is anxious to undermine the private sector. Thus Dr W.J. Pryor, who was responsible for preparing the Medical Association of New Zealand submission to the Committee, has argued,

Mr Tizard seems determined to phase out the private hospital system and force everyone into public hospitals whether they like it or not.<sup>26</sup>

Similar comments have been made by the President of the Private Hospitals Association.<sup>27</sup>

But no such inference can be properly drawn from government actions, at least up until now. First, no government subsidies of exit have been removed or diminished.<sup>28</sup> Nor does it seem likely that they will be. In his speech at the opening of the government subsidised Lister (private) Hospital extensions in Auckland, October 1973, the Hon. N.J. King, Minister of Social Welfare, began:

Let me say at the outset that the contribution made by the Lister Trust to Auckland's medical services is recognised, and greatly appreciated, by government. You have provided the only surgical hospital on the North Shore...<sup>29</sup>

It is government policy to continue the subsidy and loan schemes available to assist private hospitals. And it is essential that the government encourage the provision and maintenance of private hospitals, within the meaning of the Hospital Act.<sup>30</sup>

More recently the Hon. R.J. Tizard, Minister of Health has noted,

The Labour party had pledged to improve the standard of the public health system, but this would not be done to the detriment of private hospitals. The Government saw private hospitals filling a complementary role in medical services.<sup>31</sup>

Second, the recommendations of the Board of Health Committee which Mr Tizard could not accept, "at least for the foreseeable future", all required a change in the present relationship between government and the private sector in the direction of increased government recognition of and assistance to the private sector. Not accepting the Committee's recommendations would have simply meant the continuation of the present arrangements, under which the private sector has flourished. But, in fact, Mr Tizard did accept some of the Committee's recommendations, including in principle the recommendation that, "appropriately designated geriatric patients in private hospitals should qualify for a higher daily benefit", and, most crucial of all, "the committee's recommendation that the private hospital should be recognised as complementary to the public hospital".<sup>32</sup>

Thus, the evidence available suggests that government subsidy of exit cannot be explained simply as a byproduct of the governing party's ideology. Instead it supports the conclusion that both National and Labour governments will continue to find compelling electoral reasons for continuing and sometimes expanding the exit subsidy.

#### SUMMARY.

The evidence supports the argument that exit fails to encourage doctors, hospital boards or governments to repair public sector lapses. Instead, doctors, individually and collectively have worked to encourage exit; members of hospital boards perceive no threat from exit and governments, both Labour and National have subsidised exit as a partial alternative to the overhaul of the public sector.

#### VOICE AND THE REPAIR OF PUBLIC SECTOR LAPSES.

Does voice work better to stimulate reform? It is obvious that voice holds no terrors for the medical profession. While I assume that doctors collectively would prefer good public relations to bad, rising levels of voice impose no direct penalty on them.

Matters stand otherwise for members of hospital boards and governments (because of the power and importance of government relative to hospital boards, I will concentrate on the effects of voice on government). As I argued in chapter 1, insensitivity to voice threatens politicians'

chances of re-election; not surprisingly careful politicians spend a good deal of their time simply keeping their "ears to the ground". But what evidence is there that voice works to encourage the repair of the public sector?

In passing I have shown that the implementation of rural medical subsidies and the establishment of the Royal Commission on Hospital and Related Services stemmed from the successful use of voice. However the key argument I have advanced, that potential voice gets swallowed up by exit, suggests that examples of voice about hospital care will occur infrequently, if at all, except where exit is not readily available to anyone. Such a situation can be found in Temuka.

Temuka is a small farming centre (population 3,360 in 1973) located on the Canterbury plains, twelve miles from Timaru. Until the end of 1973 it was serviced by a small maternity hospital under the jurisdiction of the South Canterbury Hospital Board. The hospital's closure means that Temuka people needing hospital treatment for minor ailments now must go to the base hospital in Timaru for it; thus "exit" is possible, but by local standards quite difficult. Strong local sentiment means that the costs of exit are considerably higher than the simple 24 mile round trip to Timaru.

In March 1970 the South Canterbury Hospital Board made its first application to close its maternity hospital at Temuka.<sup>33</sup> Two grounds were given in the application:

a. Staffing and Standard of Care:

There was and still is an acute shortage of experienced midwives. The base obstetrical unit

was only 12 miles away and this provided a higher standard of care and enabled the Board to make a better use of such midwives as it did have.

b. Financial:

Although this was the least important consideration the Board could not ignore the fact that it could save around \$30,000 by closing the hospital and use it to greater advantage on other Services.<sup>34</sup>

According to the local Member of Parliament, Mr R.L.G. Talbot,

There was very strong opposition from all sectors of Temuka and the surrounding district to the suggested closing.

I was approached by the Temuka Borough Council, Geraldine County Council, all Women's organisation, Service Clubs, St John's Ambulance, the local Hospital Board Member, and the two local doctors. The doctors expressed concern because of their desire to serve the total needs of the family and expressed the view that they may leave the town if the Hospital closed. Public meetings were held at which expressions of opinion favoured retaining the Hospital. The Mayor of Temuka in conjunction with myself lead the campaign.

I commenced working to retain the Hospital in 1970 when it became obvious that the proposed action of the South Canterbury Hospital would have a serious effect on adequate medical services in the town. Many representations were made by me to the Minister of Health, the Hon. D. McKay, together with having informal discussions with the Chairman of the Hospital Advisory Council. Numerous questions were asked in the House and press statements made supporting the retention of the Hospital.<sup>35</sup>

The Hospital Advisory Council's recommendation that the Hospital be kept open was upheld by the Minister who expressed his concern that adequate medical services must be encouraged in rural areas.<sup>36</sup>

In short "voice" worked. As it happened, the hospital's reprieve was short lived. A second application for closure was made by the South Canterbury Hospital Board in August



1973. The grounds now were "that it was not possible to adequately staff it [the hospital] as required by the Obstetrical Regulations".<sup>37</sup> This time, under a new Labour Minister, the Board was successful. However, one of the recommendations of the Hospitals Advisory Council was, that the Board be "invited to make an appraisal on the feasibility of using the building as a community hospital or some other suitable alternative". Thus the final closure of the hospital at Temuka may not yet have occurred.<sup>38</sup>

Three conclusions can be drawn from the Temuka case study. First, it provides concrete evidence that, in the right circumstances, voice appears and works as well in the area of the provision of hospital services as elsewhere.

Second, that voice should occur in Temuka and not for example in Christchurch, is consistent with my argument that, where exit is difficult or impossible for everyone, then dissatisfied consumers are likely to resort to voice. Of course Temuka, unlike Christchurch, was threatened not with the gradual run down of public sector services, but their abrupt curtailment. I have argued that it is easier to mobilise voice in such a situation but I suspect that the fact of curtailment better explains the fury and extent of the voice reaction, rather than its simple appearance.

Third, the case study shows the considerable volume of voice that communities have at their disposal; "hell hath no fury like Temuka spurned" may well have been the local motto. Unlike Christchurch there was no need for me to hunt down voice with a questionnaire. Instead, voice was

loud and public; it involved almost all of the local organisations and had as its chief agents, the two most important local politicians; the Mayor and the Member of Parliament.

Despite a diligent search of local (i.e. Canterbury) newspapers over the last year or so, I have been unable to find traces of any other "Temukas". This fact is consistent with both of the following explanations:

- a. In those areas where exit is difficult or impossible consumers have good reason to be satisfied with the provision of public sector services; thus no voice occurs (the explanation consistent with my argument).
- b. In those areas where exit is difficult or impossible, consumers refrain from voice even although they are dissatisfied with the provision of public sector services (which contradicts my argument).

There is good reason to believe the first explanation to be correct. As Table 50 shows, "no exit" areas (i.e. those where no private sector services operate), enjoy proportionately more public sector resources than areas where exit is available.<sup>39</sup> Thus, the chances of consumers being satisfied with public sector services would appear to be much higher in "no exit" areas; the most likely explanation for the lack of voice about hospital services in such areas is that consumers are quite content with the level of service provided.

More interesting is the question of why the over-supply

of beds to "no exit" areas should occur at all. Three points from my previous discussion bear on this matter. First, for the several reasons I outlined earlier in this chapter, governments anxious to improve public sector services in an area will act to increase the number of beds available. Second, the extent of government anxiety to "do something" depends on the appearance and volume of voice. Finally, voice is only likely to appear where exit is difficult or impossible (i.e. in this case in "no exit" areas).

Table 50: Mean number of Hospital Beds in Exit and No-exit Areas.

Area	Mean no. public beds/1,000*	Mean no. all beds/1,000 *
No exit possible (11 areas)	10.9	10.9
Exit possible (19 areas)	7.5	8.6

\*Calculated from Hospital Statistics 1972.

Thus, where consumers in "no exit" areas have found public sector services inadequate I expect voice to have occurred; where voice has occurred I expect governments to have responded by increasing the number of hospital beds available. Thus, "no exit" areas should be characterised by the "over-supply" of public sector facilities relative to "exit" areas. The theory then, nicely anticipates the real world data presented in Table 50. That it does so, suggests that the past use of voice does in fact explain the present over-supply of beds to "no exit" areas.<sup>40</sup>

## SUMMARY.

I have shown how the successful use of voice lay behind the introduction of the rural doctor benefits scheme, the setting up of the Royal Commission on Hospital and Related Related Services, the delay (perhaps permanent) in the closing of Temuka hospital, and appears to underlie the disproportionate share of public sector facilities in "no exit" areas. Thus the appearance of voice, unlike exit, greatly increases the probability that governments will undertake the repair of the public sector. Because dissatisfaction with public sector services presently leads to exit and not to voice, I expect public sector deficiencies to go unremedied.

## WAITING LISTS AND REPAIR.

But perhaps the conclusion is overly pessimistic. Instead it might be argued, the very existence of the long waiting lists that lead people to exit is itself, a sufficient prod to encourage government efforts at repair.

It is true, first of all, that governments appear to be embarrassed by hospital waiting lists in a way that they are not by exit. Characteristically oppositions attack governments, not on the flight of consumers from the public sector, but on the size of waiting lists.<sup>41</sup> The present Minister of Health, the Hon. R.J. Tizard, prefaces a good number of his speeches with the assertion that the government (amongst other medical care objectives) is determined to reduce the size of waiting lists. Governments,

like it or not, are well aware of waiting lists.

It is also true that both the past National administration and the present Labour one have devoted time and energy to the problem of how to reduce the size of the lists. (In general the favoured solution has been the reduction of list size by clerical fiat, rather than by repair of the public sector).<sup>42</sup>

But it is not true that these efforts have been made simply because of the presence of long waiting lists. Instead they must be explained by what little voice does occur. Thus, a document published under the National government warns hospitals to regularly review their waiting lists, not because long waiting lists are themselves necessarily bad, but because, "Long waiting times and growing waiting lists attract criticism...".<sup>43</sup>

#### THE DIFFERENTIAL RESPONSE OF GOVERNMENTS TO VOICE.

However, hope of remedy need not yet be abandoned. The argument might continue that, while it is true that waiting lists per se exert no pressure for reform, the small amount of voice now occurring is itself sufficient in the right circumstances to bring about reform. Chief among these circumstances is the degree of sensitivity of governments to any given kind and level of voice. The constant references made by the present Minister of Health to the need to reduce waiting lists and the actions, aimed at improving the public sector, already taken by him suggest that the present Labour government is extremely sensitive to voice in this matter. Thus, despite massive

exit, the small amounts of voice occurring will be sufficient to encourage the repair of the public sector (at least for so long as Labour holds office).<sup>44</sup>

It is true that the Labour party, in office and out, appears to have paid much more attention to voice concerning hospital care, than the last National government. The difference is neatly caught in Labour's decision to dissolve the Royal Commission on Hospital and Related Matters established by their predecessors. A Labour government, Mr Tizard argued, would not wait until the 30 June 1974 (the Commission's final date for presenting its submissions) to find out how best to repair the public sector; instead Labour, through the establishment of the Caucus Committee on Health, would begin the task immediately.

The reasons why Labour party politicians should be more sensitive to voice than their National party predecessors are not difficult to find. Traditional Labour party supporters have been the chief source of what voice has occurred. Thus, as I showed in Chapter 3, in Christchurch it is Labour party, rather than National party, M.P.'s, who receive the majority of complaints about the public sector. Similarly the one hospital board member who reported many complaints was a Labour parliamentary candidate at the last election. And, using income as a rough guide to party allegiance, it is clear that those on waiting lists are overwhelmingly Labour voters.

The same is true of voice's more public manifestations. Dr Sutch and the P.S.A., for example, if not formally associated with the Labour party, are known to be sympathetic to its general aims. As well it was Labour party activists

at a Labour party conference who passed remits calling for the urgent repair of the public sector and the removal (or the removal of the need for) medical insurance organisations. Thus, the small amount of voice that has occurred, has been tightly focused on the Labour party. Not surprisingly the present Labour government appears to be a good deal more attentive to it than its predecessor.<sup>45</sup>

But the question of whether the present volume of voice is, in the present circumstances, sufficient to bring about government repair of the public sector remains. At this stage of the argument the simplest answer is that nothing that the Labour government has done so far, seems likely to improve the quality of public sector care more than marginally.

Earlier in this chapter, I argued that barring a fundamental re-organisation of the supply of medical services (which the present Labour government has certainly not yet attempted) governments can themselves only improve the public sector by making more resources available to it. One such resource is medical personnel. The present Labour government took office pledged to "immediately commence planning for a third medical school".<sup>46</sup> So far there has been little evidence of such planning.<sup>47</sup>

A second resource is finance. On taking office, the Labour government was faced with "bailing out" those hospital boards (principally the Auckland hospital board), who had overspent their appropriations.<sup>48</sup> As a result, the government introduced the controversial Hospital Amendment Bill which aimed at closing up this source of extra finance, by making board members personally liable for spending

"without due regard" for the provisions of the Hospitals Act.<sup>49</sup>

At the same time, the government increased the grant to hospital boards from the \$214 million expended in 1972-73 to \$236 million for 1973-74, an increase of about 10%. However, with inflation amounting to about the same figure for the period the real increase appears to be negligible.<sup>50</sup>

This year's (1974-75) appropriation for hospital boards of \$281 million, an increase of about 20% appears considerably more generous. However, as Mr Tizard pointed out, when the provision for increased costs of wages, salaries and supplies is excluded, the additional amount is about \$12.9 million, an effective increase in real resources of 5.8%.<sup>51</sup> But this 5.8% has to cover the extra demands imposed by a population growing at the rate of 2% a year, as well as meet a number of government goals in the provision of hospital care. As a Press editorial correctly pointed out,

The real increase in the means given to hospital boards is modest. At this rate it will be a long time before hospital services are expanded sufficiently to make good Mr Tizard's promise that "the Government is determined to improve the public hospital system and reduce waiting lists".<sup>52</sup>

#### SUMMARY: THE CHANCES FOR REPAIR IN THE PRESENT CIRCUMSTANCES.

So far in this chapter I have argued, detail by detail, that exit does not encourage the repair of the public sector, while voice does. Thus, the massive exit



characterising the present situation has not, and will not, lead to the improvement of the public sector. At the same time the volume of voice occurring at present seems to have had little effect.

#### HOW EXIT DRAINS RESOURCES FROM THE PUBLIC SECTOR: FINANCE AND MEDICAL PERSONNEL.

Earlier in this chapter I showed the ways in which governments heavily subsidise exit. Because these subsidies are linked to the volume of exit, the more exit, the greater the diversion of government medical care revenue from the public to the private sector: thus, the more exit, the less money available to the public sector.<sup>53</sup>

Public money used to subsidise the private sector is distributed according to ability to pay, rather than by medical need (no person can take advantage of the exit subsidy if he cannot first afford the cost of exit). Thus the diversion of public money from the public to the private sector, means that the taxes of those unable to afford exit, help to subsidise the "no waiting" and "personal attention" enjoyed by those who can afford it.

Exit also works to drain the public sector of its resources of skilled medical personnel. Earlier I showed that doctors, for financial and other reasons, have good cause to prefer private to public sector practice. But the possibility of private sector practice depends on the amount of demand for private sector services.

When consumers are perfectly satisfied with free public sector services, they are unlikely to pay extra to secure

private sector services. Thus (for any given cost level) demand for private sector services depends on the extent of dissatisfaction (for whatever reason) with the public sector.

Consumer dissatisfaction with public, relative to private sector services can be divided into two kinds. First, dissatisfaction may arise because of "fixed" features of public hospitals. For example, some people prefer private rooms to wards, wish for a bedside telephone, their own choice of surgeon and so on, (type 1 dissatisfaction)

The general incidence of type 1 dissatisfaction is probably low. Thus, in the present study, the most important reason for exiting was the extent of waiting lists, rather than the inherent attractiveness of private sector services. Here I am not much concerned with type 1 dissatisfaction except to note that where it exists some demand may exist for private sector services, irrespective of public sector performance and that its incidence is unlikely to change much over time. (For it to do so, either the "fixed" features of the private sector or public sector would have to change, or people would have to reappraise them; both events appear unlikely in the short term.)

The second, and most important source of dissatisfaction (type 2 dissatisfaction), is public sector performance; in particular the length of time people have to wait to secure hospital care.<sup>54</sup> Because there are wide variations in public sector performance, the amount of type 2 dissatisfaction (unlike type 1) will vary considerably over time and between localities. Because demand for private sector services is a function of the amount of dissatisfaction,

then variations in demand for private sector services are a function of variations in the amount of type 2 dissatisfaction. Thus, the unsurprising conclusion that variations in the demand for private sector services are a function of public sector performance.

But public sector performance is not all of a piece; the public sector makes a good fist of coping with road accident victims but has long waiting lists for tonsils, copes with all the demands of coronary patients but appears to be getting further behind in the treatment of varicose veins and so on.

Similarly, there are regional variations in public sector performance; while Ashburton may cope easily with the demand for routine surgery, Auckland cannot, and so on. Thus I expect demand for private sector services to vary considerably by specialty and by region.

To return to doctors; it is now clear that they will have the greatest incentive to leave the public sector for the private in those areas where the public sector does worst; i.e. doctors are most likely to work in private rather than "public" practices where the public sector is least adequate. Thus exit works selectively, draining off those doctors that the public sector can least afford to lose.

The paradigmatic example is the specialty Ear, Nose and Throat (E.N.T.). E.N.T. is the largest waiting list category nationally: at March 31, 1972 (the last date for which I have data) 9,039 people, or almost 30% of the total national waiting list, fell into the E.N.T. category (4,471 for tonsils and adenoids and 4,518 for "E.N.T. other").

Thus, on the basis of waiting list figures E.N.T. is the specialty in which public sector services are least adequate of all to public demand.<sup>55</sup>

For sometime there has been a shortage of E.N.T. specialists in the public sector. A 1968 survey of the state of surgical specialties in New Zealand concluded, "The most serious shortages belong to the field of ear, nose and throat surgery..."<sup>56</sup> Of the nine vacant E.N.T. positions in public hospitals (on the basis of the 1968 approving staffing establishment) only two had been filled by November 1973.<sup>57</sup> Clearly the public sector has had a great deal of difficulty in recruiting E.N.T. staff, even to 1968 levels.

But not so the private sector. Unlike the public sector the private sector has had available enough staff to ensure that a "no waiting service" for all of those who can afford it continues. The situation is nicely summarised in Table 51 below. Few E.N.T. specialists work full-time for the public sector (7% or less); instead most hold part-time appointments (93%) while a few more (not counted here) work only in the private sector.<sup>58</sup> With the possible exceptions of general surgery and plastic surgery, a similar trend is apparent for each of the specialties making up the waiting list (Urology, Orthopaedics, Ophthalmology, Obstetrics and Gynaecology).<sup>59</sup> In each case the number of doctors working only part-time for the public sector is considerably higher than in most other specialties; thus, in general, the worse public sector performance in a specialty, the more likely the members of that specialty to work in the private as well as the public sector.

Clearly, the distribution of doctors between public and private practice suggested by Table 51 is consistent with the outcome to be expected if, in fact, the public sector tended to lose those specialists whose services it is in most need of. However, from the data it is not possible to show the process actually at work; for this I need additional information showing how much work specialists did for the public sector at some previous time and how much they do now.

Before providing such data I should point out three difficulties in its interpretation. First, as I previously argued, the real impact of medical insurance in increasing demand for private sector services is yet to be felt, except perhaps in Auckland. Thus, whatever changes are now visible should be seen as harbingers of things to come; by the same token present changes are likely to be quite small.

A second and related problem is posed by the insensitivity of the indicators on which I am forced to rely. I have already suggested that there may be wide variations in the efficiency with which specialists work at different times or in different places; thus Auckland public hospitals treat hernia and varicose veins with considerably less efficiency than the private sector. Similarly, it has recently been argued that considerable variations in efficiency are apparent within the public sector; at least as between full and part-time appointments.<sup>60</sup>

Table 51: Specialists employed in hospital service,  
November 1973 only.\*

Specialty	Total no. employed	% employed part-time
Waiting list Specialties. { E.N.T.	40	93% (37)
{ Obstetrics	83	89% (74)
{ Ophthalmology	45	91% (41)
{ Orthopaedics	55	89% (49)
{ Urology	18	94% (17)
{ General Surgeons	154	62% (96)
{ Plastic Surgery	9	66% (6)
General Physicians	205	62% (128)
Medical Physicians	11	64% (7)
Cardiology	15	47% (7)
Chest	14	36% (5)
Diabetic	3	100% (3)
Dermatology	15	100% (15)
Infections and sterilizations	3	100% (3)
Gastroenterology	6	50% (3)
Neurology	10	70% (7)
Respiratory	3	33% (1)
Venereology	3	100% (3)
Renal	4	0% (0)
Casualty	13	69% (9)
Cardiothoracic	9	44% (4)
Neurosurgery	7	43% (3)
Vascular	3	100% (3)
Anaesthesia	133	58% (77)
Paediatrics	46	83% (38)
Pathology	62	55% (34)
Radiotherapy	12	50% (6)
Radiology	92	61% (56)
Psychiatry	76	73% (32)

Source: Information supplied by Department of Health.

\*Note only those specialties with 3 or more practitioners listed.

For such variation to appear there may be no need for the number of specialists employed by the public sector to fall or rise dramatically; some specialists may simply work much slower or much faster and quite easily make an appreciable difference to the amount of work performed in the public sector. However, the only information I have

access to concerns the number of "sessions" specialists are employed for; i.e. a formal description of the amount of time the specialist is employed by the public sector, but no record of how much he does within that time. (Each session counts 1/10 of the time a full-time specialist would work in the public sector; thus 10 sessions amount to one "full-time equivalent" the summary measure I have used in Table 52 below). Thus, considerable changes in the amount of work done in the public sector may occur, without these changes being necessarily reflected in the number of sessions worked.

Third, the data on specialist sessions in 1968 is drawn from the survey done by the Dominion Committee, Royal Australasian College of Surgeons. The reply rate for the survey was "82 percent and this was projected to 100 percent!"<sup>61</sup> I am unsure as to exactly what is meant by the latter part of this statement. Nevertheless a warning is clearly implied; when examining the differences between the numbers of sessions in 1968 and 1973 small changes, taken on their own may not mean very much. Luckily, my principal concern is not with each individual change, but the trends appearing over a large number of observations. For this purpose the data is perfectly adequate.

The data is presented in Table 52 below. Each cell contains the number of full-time equivalents (one full-time equivalent = 10 sessions) worked in each waiting list specialty in each year (1968 or 1973), in each locality.<sup>62</sup> The localities are arranged from left to right according to the amount of exit that occurred in 1973 (exit is again measured by the number of surgical admissions to private

Table 52: No. of full-time equivalents worked in waiting list specialties: 1968 and 1973.

Specialty	Hospital District															
	Auckland		Waikato		Ch.Ch.		Palm. Nth Well.		Invercargill		Nelson		Dunedin		N. Plym.	
	1968	1973	1968	1973	1968	1973	1968	1973	1968	1973	1968	1973	1968	1973	1968	1973
General Surgery	0	0	0	0	6.0	7.6	4.4	5.2	9.2	11.5	5.9	5.8	2.9	3.6	5.0	4.3
Genito-Urinary (Urology)	1.3	2.5	-	-	1.1	1.3	-	-	1.5	2.6	-	-	-	-	-	-
Ophthalmology	0	0	0	0	2.8	2.7	1.6	2.4	4.8	1.8	1.5	1.6	2.9	2.4	-	-
E.N.T.	0	0	0	0	4.6	4.3	3.1	2.1	1.3	1.1	0.6	0.7	2.6	2.6	0.3	0.4
Plastic Surgery	3.1	2.7	-	-	1.1	2.2	-	-	1.0	0.6	-	-	-	-	-	-
Orthopaedic Surgery	0	0	0	0	15.6	8.7	3.7	4.2	3.7	3.5	0.8	1.0	4.3	4.7	1.7	1.4
	10.4	8.7	3.7	4.2	3.7	3.5	0.8	1.0	4.3	4.7	1.7	1.4	-	-	2.5	3.4
	1.2	1.2	0.7	0.7	0.6	0.6	1.1	1.1	1.0	1.0	0.7	1.5				



hospitals per head of population). Thus Auckland had the greatest amount of exit and Tairāru the least. Where a decline has occurred in the number of sessions worked in a specialty I have marked it thus: 0.

The trend revealed in Table 52 is unmistakeable; the closer a locality is to the left of the table (i.e. the greater the amount of exit that has occurred) the more likely it is to have suffered a decrease in the number of sessions worked in its public hospitals since 1968. For example, Auckland has less sessions now in four of five specialist areas (it is not clear from the data what is going on in Orthopaedics) than it did in 1968. At the same time, Auckland's population has increased considerably faster than in any other area in New Zealand; in 1966-71 (the census period closest to 1968-73), the population of the Auckland area increased from 613,671 to 698,400 an absolute increase of 84,729 or 13.8%. Clearly even to provide now the same levels of service as in 1968, the Auckland public sector should have grown apace. The same is true for each of the other areas that have lost public sector sessions; in the same census period Waikato grew 9.4%, Christchurch 7.1%, Wellington 8.4% and so on.

This examination of Table 52 suggests the following conclusions. First, real decreases have occurred in the number of sessions worked in the public sector since 1968 in those specialties where the public sector is most hard pressed. Second, these decreases tend to be concentrated in areas which have experienced the greatest amount of exit. Third, to the extent that Auckland is, in fact, the first area to show the impact of medical insurance on demand

for private sector services, other areas are likely to become more, rather than less, like the "extreme" Auckland case. Finally the evidence presented and the implications drawn from it, are clearly consistent with the key argument summarised below.

#### SUMMARY.

I have been arguing that exit works to drain the public sector of its personnel resources; in particular of those specialists whose services the public sector can least afford to lose. While the available evidence, as presented in Tables 51 and 52 supports the argument's validity, the applicability of the argument extends considerably further. For any specialty, inasmuch as public sector performance leads to exit, demand for private sector services will increase and doctors will increasingly switch their efforts from the public to the private sector, irrespective of public sector demand.<sup>63</sup> Thus what is today true of, for example, E.N.T., may soon be true of many other specialties as well.<sup>64</sup>

#### EXIT AND THE DEMAND FOR PUBLIC SECTOR SERVICES.

But exit not only serves to reallocate medical services from the public to the private sector; at the same time it works to reduce demand for public sector medical services. Thus the consequences of exit are equivocal; if a great deal of demand is drawn off, but only a few medical services, those who continue as public sector consumers may actually do

better than if exit had not occurred (even although there is an overall shift from the non-market toward the market provision of medical care). Thus, the more exit occurs, the more resources are left to be distributed among fewer people, and the better public sector performance becomes. Unfortunately for public sector consumers, this is not the case. ( Instead, exit works to reduce the number of medical services available in the public sector, at a rate proportionately greater than it reduces demand.<sup>65</sup>

As the survey responses show, the key attraction of the private sector is "no waiting". The central paradox is how there can be "no waiting" in the private sector and a good deal of waiting in the public. Waiting occurs whenever the supply of medical services is exceeded by demand. The available supply of medical services is a function of the supply of physical facilities, in particular hospital beds, and the supply of medical personnel and the number of services they perform. Clearly the latter is not the crucial supply bottleneck; I have already shown that public sector beds could be employed with a great deal more efficiency than at present. Thus, waiting stems in the first instance from an inadequate supply of the services performed by medical specialists.

At any one time both the number of medical services performed and the demand for these service is finite.<sup>66</sup> In the present context, the most important characteristic of the relationship between the number of services and amount of demand is that the latter is too "small"; i.e. the total number of medical services demanded by consumers is greater than the total number of medical services being performed.

Thus, as I suggested above, waiting occurs; like the amount of demand and the number of services, of whose ratio it is a function, total waiting time is also a finite amount at any one time.<sup>67</sup> The important question is; how will total waiting time (T) be distributed among consumers?

To simplify the argument I assume that each consumer requires the same amount of medical services. Thus, in a society where the available medical services are distributed on the basis of need, the total waiting time will be shared equally among all consumers; i.e. each consumer, requiring the same amount of service as each other consumer, will wait the same amount of time to get it.

In such a society the exact length of time each person waits is a function of the ratio  $\frac{T}{N}$  (where T = total waiting time and N = total number of consumers). The important property of the ratio is that for any given amount of T., the amount of time any one consumer waits, depends on the number of other consumers also waiting, (i.e. the size of N).

Now a private sector is added to the same society; thus, those people who can afford to, can purchase a sufficient amount of the available medical services to meet their medical requirements without having to wait. Note that nothing else has changed; the addition of the private sector does not increase the total number of medical services available in the society, nor does it reduce the total amount of demand for medical services.<sup>68</sup> Consequently total waiting time also remains unchanged. But now it is distributed among fewer people, each of whom, as a consequence, has to wait proportionately longer than previously.

Thus, the exact length of time each person left in the public sector waits is now a function of the ratio

$(\frac{T}{N-p})$ , where  $T$  = total waiting time,  $N$  = total number of consumers and  $p$  = total number of consumers joining the private sector)

Clearly, the more exit (i.e. the larger  $p$ ), the smaller the denominator, and the larger the waiting time accruing to each person left.

The redistribution of waiting time achieved by the introduction of a private sector does not result from sleight of hand.<sup>69</sup> Instead, given the overall scarcity of medical services, "no waiting" is only possible for any consumer to the extent that he obtains more than the share of medical services available to him in the public sector. Thus, each person who leaves the public sector for the private (i.e. substitutes "no waiting" for "waiting") reduces demand for the available medical services in the public sector by one, but reduces the supply of services by more than one (if he did not, waiting time in the public and private sectors would be the same). Those remaining in the public sector find the available medical services, per person, further reduced; consequently, as I showed above, the time waited by each person remaining in the public sector increases.

Several conclusions can be drawn from this discussion. First, the co-existence of "no waiting" in the private sector and a great deal of waiting in the public sector depends on the fact that exit does work to reduce the number of medical services available in the public sector at a rate proportionately greater than it reduces demand for public sector services.

Second, if you are able to purchase "no waiting" service, while I am not, your privilege is won at my expense. Because your "no waiting" is won solely on the basis of purchasing power, the fact that my condition may be considerably more serious than yours, will make no difference to the outcome.

Finally, as long as an overall scarcity of hospital care, based on the shortage of specialist services occurs, then the tendency is for the public sector to lose its share of services at a faster rate than it loses consumers. Thus public sector performance tends to get worse as more and more exit occurs.<sup>70</sup> This tendency gives rise to two important consequences. First, the worse public sector performance becomes, the greater the number of people who become dissatisfied and the greater the rate of exit, which, in turn, means that public sector service gets worse, and so on.

Second, the worse public sector performance becomes, the worse the working conditions of those doctors who, for one reason or another, remain in the public sector. Because the supply of medical services reduces at a faster rate than demand for them, those doctors who are left will find themselves increasingly hard pressed. Thus public sector positions become not only financially unrewarding, but as well extremely costly in terms of personal wear and tear.<sup>71</sup> Doctors are propelled into the private sector by impossible conditions, as well as financial reward; again the public sector is likely to deteriorate still further as a result.

## SUMMARY.

The most general point made in the last two sections is that exit works to shift the allocation of medical resources from non-market to market institutions; the volume of resources distributed through the private sector is increasing while the volume of resources distributed through the public sector is decreasing.

In particular I argued that, for any specialty, once a waiting list occurs in the public sector, together with no waiting list in the private sector, then the use of private sector facilities in the specialty will increase. But because exit drains off more resources than demand from the public sector, public sector performance in that specialty worsens and a vicious circle begins.

Earlier I argued that the full impact of medical insurance on demand for private hospital services has yet to occur. To the extent that this contention is correct, then the cycle of public sector deterioration has just begun.

#### HOW EXIT DRAINS RESOURCES FROM THE PUBLIC SECTOR: ENERGY AND CONCERN.

Unlike its impact on demand for private hospital services the effects of exit in draining off energy and concern occur at once. People anxious to "do something" to remedy their dissatisfaction with the public sector gain immediate "peace of mind" with the decision to take out medical insurance.<sup>72</sup> However long waiting lists may become,

whatever else happens in the public sector, those with medical insurance can avoid public sector problems. They need no longer be concerned by public sector deficiencies; they have no personal reason to seek repair of the public sector. In fact, as the examination of voice in the last chapter reveals, people who have exited do not plan to voice.

But of course not everyone exits. First, exit only claims those who do care about the quality of public sector care; people, who would otherwise be expected to be voice's most active agents. Those people who are most concerned with public sector deficiencies, those who, in other words have the best reason to voice, are also those who exit.

Second, some people who are dissatisfied with public sector care lack the resources, or choose not to exit. Dissatisfied waiting list stayers fell into the first category. The fact that they were not claimed by exit led to passivity rather than voice. The reason, as I argued in Chapter 3, was that of all of those people on the waiting list dissatisfied with public sector care, exit worked to select out those who had more rather than less political resources and energy. Consequently, while exit fails to drain off all energy and concern, it leaves as its residue those people who have the greatest difficulty in using voice effectively.

As well, some people who are dissatisfied and can exit, choose not to, or, if they should exit, continue to be concerned about public sector deficiencies. Such people put value on the provision of the best possible care through the



public sector as an end in itself. For them, while exit may secure them personally better medical care, it makes no difference to their concern that medical care be distributed through non-market arrangements. Earlier, I identified such people as ideologues and showed how they appear to be the source of the little voice that has occurred.

Ideologues who give public expression to felt discontents shared by a large number of people, can normally be expected to win a following of some kind. That ideologues, voicing dissatisfaction with public sector medical services in New Zealand, have not won such a following is a key part of the general problem, "why little or no voice" that I have been examining. So far I have couched the explanation simply in terms of the fact of exit: that exit works to drain off those who, otherwise, would be voice's most active agents.

Also important, and as yet unexamined, is the way in which exit occurs. Exit involves many individual, uncoordinated decisions spread over time and space. How much information people have about public sector defects, how much they care about them, what opportunities they see for remedy and so on, varies widely. Thus, at any one time, relatively few individuals make the decision to exit; the rolls of medical insurance organisations grow as a result of the day to day trickle of new policy holders, rather than by massive leaps and starts.

That exit works as a "trickle" process has two important consequences. First, those who are dissatisfied with public sector services, remain unaware of the extent to which their dissatisfaction is shared; thus they remain unaware of the possibility of collective, rather than individual remedies.

A second and related consequence is that, at any one time the potential audience for an ideologue advocating a collective solution is relatively small, even although over time a great many people may have become dissatisfied with public sector services. Neither the medically insured (who after all, pay their premiums to assure themselves of "peace of mind") nor those satisfied with public sector care are likely to pay much attention to the ideologue's advocacy. Thus he must draw his audience from among those who, while dissatisfied, have not yet exited.

The first group who fall into this category are those sufficiently dissatisfied to want to "do something" but who have not yet exited, even although they have the necessary resources. The problems posed by this group are small size and high turnover. For any given time period  $t_1$ , only a tiny fraction of those who (at present) eventually exit, will occur in this category; the rest will be found either among the "still satisfied" or the "already exited".<sup>73</sup> Thus the ideologue's first potential audience has a rapidly changing, but always relatively small, membership.

A second possible audience is made up of the residue left by exit: all of those people who are sufficiently dissatisfied to want to "do something" but who lack the resources to exit. To the extent that a cycle of progressive deterioration sets in, in the public sector, this audience may become quite large.<sup>74</sup> But this audience, too, poses problems for the ideologue.

Because exit works to select out those people with more political resources and energy, exit's residue comprises just those people who are most difficult to reach, most

difficult to inform, and most difficult to organise in any way. Ideologues are likely to have trouble simply gaining their attention.

Thus the fact that exit works to drain off energy and concern through a "trickle" process, still further reduces the possibility of effective voice. Those who are actively dissatisfied will generally remain unaware of the possibility of collective, rather than individual remedies; those who might advocate collective remedies will find it difficult to gain the attention of their potential audience.

But, like other resources drained off by exit, energy and concern does not simply disappear. Instead it becomes invested in the private sector and some aspects of the public sector. As long as those people who have exited can get better service from the public and private sectors in combination, than from the public sector alone, they will oppose government attempts to restrict exit and support those which promise to ease it.

I have already shown that those who exit have more concern (i.e. are more quality conscious) than most others and as well include disproportionate numbers of those with high political energy and resources. Those who exit should find it easier than others to wield political clout. But it is difficult to find situations in which such clout could be expected to appear; for example, since 1950 neither National or Labour governments have attempted to restrict exit.

However, the Marylands residential home for retarded boys in Christchurch, provides a suggestive case study of the mobilisation of voice on behalf of private sector

services. The home, it was argued, would be forced to close its doors unless the government provided sufficient money to allow its re-building and subsequent operations. After a sustained (and continuing) campaign, the government agreed. In chapter 3 I showed how these efforts showed up at one of the voice collection points I examined; 50% of all letters to the editor dealing (even remotely) with hospital care, published in Christchurch for the year September 1, 1972 to August 31, 1973, dealt with Marylands; all of them protesting its closing. Marylands, at least, could mobilise a great deal of voice energy in its support.

But those who have exited hardly need to voice on their own behalf; their interests have always been actively represented by others. Southern Cross opened their submissions to the Board of Health Committee's Inquiry into Private Hospitals by pointing out that many of those making use of private hospitals had medical insurance; thus,

The Health Insurance movement can therefore claim with some justification to speak on behalf of the patients [i.e. private hospital patients] - or a considerable number of them...<sup>75</sup>

They were correct. Southern Cross, the Medical Association of New Zealand, the Private Hospitals Association and others argued the need for increasing government support and subsidy of the private sector before the Board of Health Committee.<sup>76</sup> The arguments were well documented and expertly presented; they served the interests of those who made them and the interests of those who have exited.<sup>77</sup>

In fact the interests of private hospital users have always been looked after by organisations such as M.A.N.Z.,

the Private Hospitals Association and of late, Southern Cross. It has been their efforts which have encouraged and justified the increasing government subsidy of exit. However, the fact of massive exit gives their arguments new cogency. First, they can claim, quite correctly to speak on behalf of many more people than previously. Second, those who have exited themselves constitute an important political resource; they include those who care most about what sort of medical service they get, and who are most able to "do something" to get it.

I have pointed out that, as long as the discrepancy in service between the public and private sectors remains, any government which seeks to restrict exit is likely to face widespread public outcry. Conversely, government action to make exit easier, will be welcomed by more and more people. Of particular interest here, is the situation in which exit increases sufficiently to overburden existing private sector facilities. Then it seems that governments, regardless of their stated policy, will be subject to heavy and increasing pressure to subsidise the building of additional facilities. Exit is unlikely to be ended by the inability of the private sector to provide beds.

Both Labour and National governments have found in the past sufficient reason to subsidise exit. The switch of energy and concern from the public to the private sector means that they will have better reason in future. In particular, if a government decides that improvement of the public sector requires the restriction of exit, it will face the organised outrage, not only of doctors, private hospitals and medical insurance organisations, but as well, the

opposition of the large and increasing number of potentially articulate people, who benefit by exit.

But the public sector retains some of the energy and concern of those who exit. Private sector facilities remain limited; as the Chairman of the North Canterbury Hospital Board pointed out, "Private hospitals can't possibly provide the highly expensive equipment of the super-specialties e.g., Radio Therapy or Nuclear Medicine".<sup>78</sup> Thus, those who exit may, nevertheless, continue to care a great deal about the provision of those public sector services for which no private substitute exists.

I do not have available any evidence that bears on this point. Nevertheless it seems reasonable to assume that those who have exited, and those who have a vested interest in sustaining large scale exit, will generally support efforts to reallocate public hospital resources from specialties in which the public and private sector compete to specialties in which the public sector has a monopoly.

Doctors operating in those specialties in which the public sector has a monopoly, (i.e. in general, the "super specialties") will work hard to get their plans and projects for expansion accorded high priority. On the other hand, doctors who work part-time in the public sector, in "waiting list" specialties, will be reluctant to have more resources allocated to their specialties in case the private sector demand for their services diminishes.

Hospital boards are likely to approve such reallocation. They have good reason to keep their medical staff happy, which reallocation in this way does. As well, those on the waiting list are by definition "non urgent" cases, while the needs of patients handled by the "super specialties"

usually appear more pressing. Again reallocation appears the "right" thing to do.

And the public will apparently be happy as well. All of those people who exit can have their cake and eat it too: by switching judiciously between the public and private sectors, they guarantee themselves the best care and the shortest waiting times. All of those people who cannot exit and have to wait, will most likely remain quiet. (Note the converse point; those who exit are likely to bitterly oppose moves to reallocate resources toward the waiting list specialties; doctors, who publicly complain that their efforts to prolong life through the use of new and expensive techniques are being stymied by lack of resources, are likely to win sympathetic audiences; the fact that they are likely to do so will undoubtedly influence administrators' decisions).

Thus, exit ends concern about the quality of only some public sector services. If my argument is correct, this fact leads to the increasingly disproportionate allocation of resources within the public sector. "Waiting list" specialties tend to lose resources while "super specialties" tend to gain them; this arrangement apparently leaves everyone happy. Unlike the move in the opposite direction, any attempt to change the allocation of resources in favour of "waiting list" specialties is likely to be resisted. Thus, over time, two standards of service should develop in the public sector; the very best standard of care and attention in each of the specialties in which the public sector has a monopoly, a somewhat lower standard of care and attention in those specialties in which public and private sector compete.

As I noted above I have no evidence available to test the argument's validity. However the argument itself is precisely analogous to one I presented earlier: that areas in which exit was impossible would win a disproportionately large share of public sector resources, while areas where exit was possible would win a disproportionately low share. I showed how, in fact, "no exit" areas had bed ratios (used here as a measure of the allocation of resources) considerably higher than "exit" areas. In the former argument the areas were geographically defined; in the present argument the areas are medical ones but the logic of both is the same.

#### SUMMARY.

Exit drains off public sector resources of energy and concern immediately; the way in which the process occurs considerably reduces the chances that effective voice strategies will be found. The energy and concern drained from the public sector reappears in the private sector, increasing the bargaining resources of those seeking government assistance to the private sector. As well it remains attached to those hospital services of which the public sector has a monopoly; over time this may result in the disproportionate allocation of public sector resources.

#### PUTTING IT TOGETHER: THE CONSEQUENCE OF EXIT AND VOICE COMPARED.

The evidence presented in this chapter shows that it makes a great deal of difference to the public sector whether those anxious and able to "do something" choose



exit, rather than voice. Exit encourages no one to repair public sector services; as well it drains off resources of personnel, finance, energy and concern on which public sector improvement depends. Consequently a vicious circle sets in: public sector performance worsens, more people become dissatisfied and exit, public sector performance worsens further and so on. Here consumer efforts to remedy dissatisfaction lead to worse, rather than better public sector performance, and more, rather than less exit.

Voice has the opposite effect: it works to encourage repair of the public sector and it conserves public sector resources. The process set up by its adoption is exactly opposite to exit; dissatisfaction, which leads to voice, results in attempts to repair the public sector which leads to less dissatisfaction and less voice and so on. Here, consumer efforts to remedy dissatisfaction, lead to better, rather than worse public sector performance and less, rather than more voice.

Although small amounts of voice have occurred, it is clearly the exit process which dominates the public sector. In the final chapter I examine some of the implications of this fact.

#### CHAPTER SUMMARY.

The evidence presented supports the following contentions:

1. Exit, unlike voice, does not stimulate efforts to bring about the repair of public sector lapses.
2. Exit, unlike voice, works to drain off public sector

resources of finance and personnel (although the effect will be delayed).

3. Exit, unlike voice, drains off resources of energy and concern from the public sector, reducing the possibility of voice, and thus, public sector repair.

NOTES.

<sup>1</sup>The best example remains the experience of the first Labour government in its attempts to implement its election policy on the welfare state provision of medical care. For a blow by blow account of the negotiations between the government and the profession, See: J.B. Lovell-Smith, The New Zealand Doctor and the Welfare State.

<sup>2</sup>Medical Association of New Zealand, "Submissions to the Board of Health Committee on Private Hospitals." (mimeo., 1972), p.1.

<sup>3</sup>The Summary section of the submission reads:

1. The most urgent need for Private Hospitals is a realistic patient subsidy tied to a cost of living or salaries index.
2. Most Private Hospitals should be "Trust" or non-profit making.
3. There should be co-operative sharing of expensive facilities by Public and Private Hospitals.
4. The licencing of Private Hospitals should remain with the Health Department.
5. The Medical Benefit, should be more, nearly the same as the Surgical Benefit.

Ibid; p.3.

Thus, all but two of the recommendations made, involve increasing government subsidy of exit.

<sup>4</sup>The information is from, G.C. Salmond and E.M. O'Connor, "General Surgical Waiting Lists and the Management of Varicose Veins." New Zealand Medical Journal, 78 (1973), 394-400. They report that, in 1970, patients waiting for treatment for varicose veins made up 67% of the total Auckland waiting list for general surgery and 17% of the overall Auckland waiting list. Hernia patients comprised 15% and 4% of the Auckland general surgery and overall waiting lists respectively.

<sup>5</sup>It is, of course, possible that there is some radical difference in the type of patients treated or the type of treatment given at private hospitals; however there is no evidence to support this hypotheses and my private inquiries suggest that it is implausible.

<sup>6</sup>Ibid. From the information provided I computed public hospital mean stay figures as follows:

I multiplied the average length of stay in each of the three major Auckland public hospitals (Auckland, Green Lane, and Middlemore) by the number of patients

treated, and added the three totals together. I then divided this total by the number of patients treated for each condition to determine the mean day stay.

The mean length of stay for the three "unnamed" private hospitals for which information is given is computed by Salmond and O'Connor, pp.397-398. Unfortunately there is no information available for private hospitals before 1972.

<sup>7</sup>It seems to me unlikely that each board member has thought deeply about the questions involved, made a quick calculation of where his/her self interest as a board member lies and replied accordingly. No such claim is being made here. Instead, whatever the source of a person's original attitude, the logic of a board member's position is such that existing pro-exit attitudes are unlikely to be contradicted.

<sup>8</sup>See Appendix 3.

<sup>9</sup>Some hospital board members not only approve of exit but also actively seek to promote it. Thus, for example, some members of the North Canterbury hospital board also serve on the boards of Christchurch private hospitals.

<sup>10</sup>Hon. R.J. Tizard, "Address to the Medical Association of New Zealand," (mimeo;1973). The recent publication of two studies, providing quantitative data on the comparative efficiency of public hospitals, allows the government to substantiate its claim on the need for better management, but provides no new means to implement government wishes. See: G.C. Salmond, "A Comparative Study of Disease Specific Lengths of Stay in New Zealand Hospitals." Occasional Paper, Number 1, (Wellington: The Department of Health, 1972); G.C. Salmond and E.M. O'Connor, "General Surgical Waiting Lists and the Management of Varicose Veins".

<sup>11</sup>The strategy is to some extent self defeating. By a variant of Parkinson's Law, the supply of hospital beds tends to determine the demand for them. As Professor B. Abel-Smith argues,

"In general it can be said that areas which already have fewer beds seem still to need fewer beds, while those having more beds seem to need all the beds they have... within limits supply can create its own demand..."

(quoted in G.C. Salmond, "A Comparative Study of Disease Specific Length of Stay in New Zealand Hospitals"). Nevertheless real differences in the waiting list's size as a percentage of population occur between "over" and "under" "bedded" areas. Thus in Ashburton (which has one of the highest public bed to population ratios) 0.2% of the population are on the waiting list, while in Auckland the proportion is 1.2% or six times as high (Auckland has the

worst public hospital bed to population ratio). See; Department of Health, Hospital Statistics of New Zealand, Year Ended 31 March, 1972. (Wellington, Department of Health, 1972.)

<sup>12</sup>The other major option open to government is to increase the supply of medical practitioners available, which, of late, both National and Labour governments have sought to do. However, unlike the provision of public hospital beds these efforts do not constitute a useful indicator of government anxiety to improve the public sector:

- a. because changes in the provision of hospital beds occur in a specific locality, presumably in response to pressures from that locality, whereas increasing the supply of doctors gives no clue as to where the pressure for the change originated
- b. the beds provided are a gain specifically to the public sector while doctors can, and do, work in both sectors.

<sup>13</sup>Information on number of public hospital beds per 1,000 and population of each hospital board district, is from Hospital Statistics of New Zealand Year Ended 31 March 1972. I calculated the exit ratio by dividing the number of surgical admissions to private hospitals in each health district (from information supplied by the Department of Health) by the population of the corresponding hospital board district and recorded the answers as a percentage.

<sup>14</sup>The Royal Commission was established in March, 1972, and dissolved by the new Labour government in February, 1973. Before its dissolution, the Royal Commission reported on the question of the justification of a salary advantage in favour of psychiatric and psychopaedic nurses over other kinds of nurses. It also completed two interim reports also arising out of its investigations into psychiatric services.

<sup>15</sup>The preamble to the Commission's terms of reference states that the Commission is to,

receive representations upon, inquire into, investigate and report upon the existing facilities and the future requirements for hospital and related services for New Zealand and the resources to provide such services, and to recommend such measures as you believe will ensure adequate provision of such services.... The New Zealand Gazette, March 2, 1972. p.440.

<sup>16</sup>Cf. the following:

As a direct consequence of the unrest in psychiatric hospitals... the Royal Commission was set the difficult

task of reporting on an integrated service in three distinct and time separated stages .

Department of Health, The Public Health Report of the Department of Health for the Year ended 31 March 1973. (Wellington: Government Printer, 1973) p.25.

<sup>17</sup>The New Zealand Gazette, March 2, 1972. p.441.

<sup>18</sup>The quotations given are from a letter to me from the Hon. L.R. Adams-Schneider, dated September 20, 1973. I had written to Adams-Schneider on August 29, 1973, asking:

For what reasons did the National Government set up the Royal Commission to Inquire Into and Report Upon Hospital and Related Services in New Zealand (i.e. why not have it earlier or later etc.)? How important in determining the scope and timing of the Commission was the staff unrest in psychiatric hospitals? What other factors were involved in deciding to set up the Commission?

<sup>19</sup>Section 3(b) of the Hospitals Act 1957.

<sup>20</sup>According to the Department of Health,

Recognising the important part played by private hospitals in the overall provision of hospital beds in New Zealand, the Government introduced a private hospital loan scheme in October 1952, and this was later extended in 1954, following recommendations made in the Barrowclough Report, to provide suspensory loans, the terms of which were further liberalised in 1956.

Department of Health: A Review of Hospital and Related Services in New Zealand (Wellington: Government Printer, 1969) p.20.

<sup>21</sup>Board of Health, Private Hospitals in New Zealand, p.27. The matter was put more bluntly in another government document I came across,

In considering applications for loans close attention is paid to the essentiality of the type of beds being provided and the extent to which the provision of equivalent beds by hospital boards is thereby avoided.

<sup>22</sup>Figures on the number of public sector beds per 1,000 of population taken from Hospital Statistics of New Zealand Year Ending 31 March 1972. The figures on the allocation of loan money is compiled from material made available to me by the Department of Health.

<sup>23</sup>Radiological services are partially subsidised and

Specialist Consultation Benefits and the General Medical Services Benefit are likewise available to those using the private sector. In its submissions to the Royal Commission on Hospital and Related Services, the P.S.A. argues that the state paid training of nurses and doctors should also be counted as an additional and very expensive subsidy provided by the state to the private sector. The submission estimates that

Total cost to the State of having trained the doctors and nurses at present working full-time or the equivalent of full-time in private hospitals: \$13,992,300.

Public Service Association. P.S.A. Newsletter, p.55.

- <sup>24</sup>In the present kind of circumstances. As I argued in Chapter 1, from time to time extraordinary circumstances arise when large groups of people, unused to the experience find themselves medical "paupers", all at the same time. In such circumstances the best strategy for government will be the implementation in whole or part of welfare state medicine.
- <sup>25</sup>Such an explanation does not work for the continuation of subsidies under the Nash government at the end of the fifties. But perhaps ad hoc explanations could be thought up; for example the difficult economic circumstances facing the Nash government, together with its short term of office, explains why the subsidies continued even although the government would have seemed ideologically opposed to the expansion of the private sector.
- <sup>26</sup>The Press, March 28, 1974.
- <sup>27</sup>The Press, April 1, 1974.
- <sup>28</sup>It is, of course, possible that the actual amounts paid out under the loan schemes has diminished even if the rates of subsidy have not been changed. At the time of writing no figures on payments made by the new Labour government are available.
- <sup>29</sup>From the Minister's speech it appears that the total cost of the extensions was \$220,000. Of this the government approved loan money to the extent of \$130,000 at 5% interest. But part of this loan is suspensory; 20% of the approved cost of equipment and 10% of the approved cost of the buildings. Suspensory loans are free of interest and written off after 10 years.
- <sup>30</sup>Hon. N.J. King, "Speech at the opening of the Lister Hospital extensions, Auckland, Saturday, October 13, 1973". (mimeo) In the same speech the Minister stated,

"Let me commend the trust too for its policy of making a free bed available for needy patients", something it seems unlikely that members of the first Labour government would have done.

<sup>31</sup>The Press, January 26, 1974.

<sup>32</sup>The Press, March 27, 1974. As well Mr Tizard,

favoured the recommendation that local hospital boards meet the cost of transferring a patient from a private hospital to a public hospital.

In an earlier statement (The Press, January 26, 1974), the Minister said,

Consideration was being given to extending to private hospitals the bulk-buying system but this would not boards (sic) to save costs on many items.

<sup>33</sup>Section 55 of the Hospitals' Act 1957, provides that a board may close an institution only with "the prior consent of the Minister given on the recommendation on the recommendation of the Hospitals' Advisory Council". Also a board may close an institution for "a period not exceeding three months at any one time" without such consent. The South Canterbury Hospital Board twice made use of this clause in the period 1970-1973.

<sup>34</sup>Information from a letter, to me, by the Chairman of the South Canterbury Hospital Board, Mr R.H. Kerr, 23 January, 1974.

<sup>35</sup>On this point the Chairman of the South Canterbury Hospital Board writes,

Two Ministers of Health were involved - one under the former National administration and the present Labour Minister. There is no evidence of intervention by either Minister. On both occasions the Minister merely approved the recommendation made to him by the Hospitals' Advisory Council as provided in the Act. On neither occasion did the Board have any dealings directly with the Minister.

Ibid.

However it was done, the lobbying was nevertheless effective in turning what might have been a routine



administrative decision, into one of considerable moment.

<sup>36</sup>Letter to me from Mr R.L.G. Talbot, Member of Parliament South Canterbury, February 15, 1974.

<sup>37</sup>Mr R.H. Kerr, January 23, 1974. Mr Kerr also argues:

One of the main reasons which influenced the thinking of the Advisory Council in September, 1970, when it declined the application of the board to the permanent closure, was the evidence presented to it on the submission that the lack of any obstetrical facilities would make the town very unattractive to doctors wanting to practice there. Since then this aspect has undergone a change in that it is said young doctors now-a-days do not want to practice obstetrics - preferring to leave this to specialists in this field. This was supported by a young doctor recently commencing practice in the town without any prospects of, or indeed any desire for obstetrical work.

<sup>38</sup>Mr Kerr wrote that the board was bound to carry out the recommendation and that

it is to ask the Department to define for it what is expected of a community hospital in a location such as Temuka.

In the meantime, Mr R.L.G. Talbot writes, February 15, 1974,

I am making representations to the Minister of Health asking him to recommend to the South Canterbury Hospital (sic) that the Temuka Maternity Home be developed as a Community Hospital. Such a proposal would be acceptable to the people of Temuka and would be of some assistance to doctors in the district.

<sup>39</sup>The disproportionate number of beds found in "no exit" areas, is even more striking, once it is realised that hospitals in such areas provide considerably fewer services to their clients than most hospitals in "exit" areas. Thus, to take the most obvious example, not only does the Auckland Hospital board provide a number of services that West Coast hospitals do not, for example heart surgery etc., it also provides these services to people from all over New Zealand, including those from the West Coast. Thus, assessing the distribution of resources by public sector beds per head of population in each hospital board area, systematically understates the discrepancy between "exit" and "no exit" areas.

<sup>40</sup>The division into "exit" and "no exit" areas is a very

crude one, in that it fails to allow distinctions within hospital districts. Thus, in the analysis Temuka (for example) is treated as part of the South Canterbury hospital board area. Even so, the data supports my argument.

<sup>41</sup> See R.J. Latimer, "Introduction", in R.J. Latimer (ed), Health Administration in New Zealand, p.11.

<sup>42</sup> In A Review of Hospital and Related Services in New Zealand prepared by the Department of Health, under the last National administration, hospitals are advised;

Limited surveys of waiting lists have shown that there is considerable scope for improvement in their operation. In general too little regard is had for the personal and economic responsibilities carried by those on the waiting lists. Much more can be done toward changing orientation from a "waiting list" concept to that of "arranged admission". Long waiting times and growing waiting lists attract criticism and among other things hospitals should ensure that people on waiting lists are still alive, have not moved away and are still in need of hospitalisation. A quarterly check by every general hospital appears an appropriate requirement of management, and a classification by "average waiting time" by categories of diagnosis, is probably more significant than the gross totals of the list.

A Review of Hospital and Related Services in New Zealand, Department of Health (Wellington: Government Printer, 1969), p.74.

The Labour government's 15 point plan to reduce waiting lists, announced by the Minister of Health in April 1973, has a similar flavour. As well as recommending that more efficient use be made of outpatient facilities to deal with waiting list cases, that full-time directors of surgery be appointed, and so on, it suggests:

1. That urgent patients should not be put on the waiting list but be firmly booked for an operating session within 10 days.
2. That no one be put on the waiting list without first being examined at the outpatients clinic of a public hospital. (Thus "unnecessary" cases are screened out; meanwhile the three months or more, that patients in some centres typically wait to be seen at outpatients, no longer appears on the waiting list).
3. That hospital boards should increase their clerical reviews of waiting lists by the distribution of questionnaires at three-monthly intervals. Patients whose symptoms are susceptible to spontaneous remission, who are classified as routine and who have been on the waiting list for six months or more should be subject to medical screening.

The Press, April 21, 1973.

<sup>43</sup>Department of Health, A Review of Hospital and Related Services in New Zealand, p.74.

<sup>44</sup>Hirschman points out that in situations like the present one characterised by the massive resort to the option least effective in stimulating reform, any use of the alternate option works to increase the chances of repair. A.O. Hirschman, Exit Voice and Loyalty, p.35.

<sup>45</sup>Perhaps Labour's politicians are also ideologically predisposed to pay close attention to such voice. However the point that I wish to make here is, that even if Labour party politicians were ideologically identical to their National party counterparts, I would still expect Labour to be more likely to repair the public sector than National, simply because of the focus of the voice that has occurred.

<sup>46</sup>The New Zealand Labour Party, 1972 Election Manifesto (Wellington: Standard Press, 1972), p.21.

<sup>47</sup>The main vote to hospital boards was overspent by roughly \$3 million, of which the Auckland hospital board's share was about \$1.8 million. The Press, October 25 and October 29, 1973.

<sup>48</sup>Tuesday 27 February 1973, right after the Labour party had assumed office, the Minister of Education was asked by the Hon. L.R. Adams-Schneider,

What action has he taken to carry out the policy of the Labour party that planning for a medical school would begin the day the Minister assumed his portfolio?

The Minister replied,

Planning for the third medical school for New Zealand is definitely underway, but it became quickly apparent in our planning that the needs of the country, and the need to have an uninterrupted supply of doctors, would best be achieved by enlarging the existing schools rather than developing immediately the third medical school. The planning, which has gone a long way towards the preparation of plans and estimates, has been the subject of a number of discussions between myself and the Minister of Health and his officers, and the Department has been directed to obtain information on a number of aspects. But it is part of our planning that options should be kept open, and the view expressed by my colleague, the Minister of Health shows (sic) us to do just that...

Parliament, 1973, No 2. The most optimistic assessment of the present situation (that I have heard) is that the principal option, that there may be a third medical school, may still be open.

49 In its first reading the relevant clause read that board members would be liable for spending, "in reckless disregard" of the provisions of the Hospitals Act. The change to "without due regard" was the result of strenuous protest by hospital boards and others (the change, as the Minister of Health admitted at the bill's second reading, still did not satisfy the Hospital Boards' Association.) The Press, October 25, 1973.

50 The Press, April 3, 1974.

51 The Press, March 30, 1974.

52 The Press, April 3, 1974.

53 Assuming, of course, that money not spent on the private sector would go to the provision of health rather than other government services.

54 Some other kinds of type 2 dissatisfaction include dissatisfaction about hospital location, the reputation for laxness of a particular superintendent, and so on. On the basis of my survey results none seem very important compared with the problem of waiting time.

55 In comparison, 7,992 people were reported waiting for general surgery, 5,672 for Orthopaedic surgery, 1,253 for Genito-Urinary surgery, 1,701 for Ophthalmology, 2,475 for Gynaecology and 2,380 for Plastic Surgery. Department of Health, Hospital Statistics of New Zealand Year Ended 31 March 1972.

56 Details of the survey are given in Joint Committee on Medical Graduate Needs, Report on Medical Graduate Needs in New Zealand for the Years 1968-2000 (Wellington: Department of Health, 1970), pp.28-41.

57 Figures on the 1968 situation are from Ibid, p.31. In an interview with one of the people in the Department of Health concerned with deciding what is the "approved establishment", I tried to find out how the numbers were arrived at. It appears that the procedure, while precise in the sense that other people with similar training are likely to reach the same conclusion, is reached intuitively by the application of a number of rules that apparently only experience teaches. One of these rules has to do with the number of people potentially available to fill vacancies; clearly if there is little or no likelihood of present vacancies being filled in a specialist area, it makes

little sense to further increase the establishment. Thus it is likely that the "approved establishment" figures for E.N.T. understate (I have no idea how much) what would be a desirable figure, given an adequate supply of potential recruits.

Information on the present situation is from a list drawn up by the Department of Health (for me) of specialists in hospital service, November 1973. Clearly it would have been most useful to have such a list for 1968 (and other years) as well. However, the Department was reluctant to do more because of the considerable time and effort involved in drawing up the list for one year. Having ultimately been persuasive enough to get the figures for 1973, and knowing the pressure the people concerned were working under, I did not press the matter further.

<sup>58</sup>For example, The Joint Committee, Report, lists three doctors in Auckland who work only in private practice. Thus the figures given in this table for each specialty may understate the share of the private sector in the distribution of doctors. As I have no up to date information on the number in each specialty who work in private practice only, I have made no attempt to estimate them in the table. However to the extent that such people exist, then the central argument is further supported.

<sup>59</sup>The low figure for general surgery is probably explained by regional variation; thus in Auckland, Wellington and Christchurch, where the bulk of the national general surgery waiting list is drawn from the percentage of part-time employment is much higher (80%, 72% and 92% respectively). However, because even the smallest hospitals (with little or no waiting list) have general surgeons who are employed full-time, the overall "part time" percentage is nonetheless low.

<sup>60</sup>The Press, November 16, 1973..

<sup>61</sup>Joint Committee, Report, p.28.

<sup>62</sup>Because I have no data on obstetrics and gynaecology for 1968, I have been forced to omit them. However the table includes each of the other specialties included on the waiting list.

<sup>63</sup>As long as sufficient private sector demand exists, any doctors who shift back to the public sector will be financially penalised, regardless of public sector demand. If anything (as I will explore in some detail below) increases in public sector demand make it even less likely that doctors will shift from the private to the public sector. Any doctor who does so suffers not only financial penalty, but is also likely to be worked off his feet.

Thus, so long as private sector demand continue, traffic from the public to the private sector will be one way only.

64 The caricature of doctors as a species of "economic man" is based on expected outcomes, over time. Thus for all kinds of reasons (including personality differences between doctors, the cost of setting up in private practice, doubts about the amount of demand and so on) at any one point in time there may be a gap between private sector supply and demand (although private hospitals have so far maintained a "no waiting" service). However my argument is that, over time, the outcome will resemble that which would occur if, in fact, doctors acted as a species of "economic man".

65 I suspect that this outcome is the one found everywhere that public and private sector medicine co-exist; the extreme example is of course the United States where some of the best and some of the worst medical care facilities exist side by side, the one in the private sector, the other in the public (more accurately the "charity") sector. However, the outcome is not logically necessary; it would not occur, for example, without a scarcity of resources, or where the buying power of the public sector was greater than that of the private.

66 Thus exactly so many medical services were, in fact, performed yesterday; similarly there was, in fact, so much demand yesterday.

67 Total waiting time is a function of the ratio of the demand for medical services and their supply. Thus symbolically:

T is proportional to  $\frac{D}{S}$  for every value of  $\frac{D}{S} > 1$   
(where T = total waiting time, D = demand for medical services and S = supply of services).

Thus the larger the demand for the same amount of resources, the larger the amount of total waiting time.

68 Three objections may be raised at this point. First, it might be argued that the provision of the private sector, in the long run, works to increase the supply of medical services available by making doctors' careers more attractive as a result of increasing the amount of money doctors can expect to earn. However, already there are many more people who would like to become doctors than there are places available in medical schools; as well, no matter how much doctors' incomes increased, no more doctors than at present can be produced by the medical schools.

A second objection is that the introduction of the private sector does, in fact, work to increase the total number of medical services available simply because (as my data

suggests) doctors appear to work much harder in their private than their public sector capacities. But this objection begs the question; the key point is the distribution of the services being performed at any one point in time; if more services become available for whatever reason (more specialists appear, the available specialists perform more services) then, to the extent that the private sector gains a disproportionate share, the public sector share is reduced.

A third, and related objection, is that the number of medical services available would decrease without the private sector, because fewer doctors would be attracted as immigrants to New Zealand or because more New Zealand specialists would leave. The argument refers to a future rather than present event; it also depends on the assumption that no effective countermeasures for such a process will be found (for example a drastic increase in specialist salaries and a general improvement in their working conditions). Thus the argument may or may not be valid; but it has little to do with the present distribution of medical services between the public and private sectors.

<sup>69</sup> This assertion is a restatement, in social science terms, of the natural sciences most fundamental theorem, "energy is neither created nor destroyed". Social scientists such as myself have tended to shun such a rigorous formulation. My own preference is for the form, "there's no such thing as a free lunch", but the reader should be warned that others prefer, "you can't get something for nothing!"

<sup>70</sup> At first deterioration may be only relative; i.e. all of the extra services performed will go to the private sector and not to the public; thus while private sector capacity to cope with increased demand rises, public sector capacity remains the same. In such a situation waiting lists will not rise. However, once specialists are working at peak rates in the private sector then additional demand can be met only by switching "sessions" from the public to the private sector; at this point waiting lists (or waiting times) will begin to rise.

<sup>71</sup> At present only those people who cannot escape the public sector, in particular house surgeons; bear the full brunt of the fact of too many services to be performed by too few people. I would imagine that few specialists would be prepared to spend a life time working under the conditions that house surgeons put up with.

<sup>72</sup> The phrase, "peace of mind", is from a pamphlet advertising the virtues of Southern Cross. Other phrases with similar meaning can be found in most medical insurance advertising.

- <sup>73</sup>The more efficient medical insurance salesmen are, the smaller the number occurring in this category. The salesman's task is first to reach, and then sell, his company's policy to all of those dissatisfied. As well salesmen seek to convince doubtful prospects that the public sector really is "that bad", and that the prospect is very dissatisfied with the service it offers. As part of the fieldwork on this project I accepted the advertised offers of two medical insurance companies to have their salesman call and tell me about their product. In both cases, after I had hinted that I wasn't sure about the need for me to have medical insurance at all, I was told stories about people who had waited a long time, in considerable pain for public sector treatment. I expect the stories were true (although, perhaps atypical).
- <sup>74</sup>If everyone who could, exited (as in the United States), then the size of the residue would probably be about 20% of the population.
- <sup>75</sup>Southern Cross Medical Care Society, "Submissions 1972".
- <sup>76</sup>Those making such arguments included the New Zealand Nurses' Association, the Trustees of the Lavington Trust Hospital, and the Royal Australasian College of Surgeons.
- <sup>77</sup>The Private Hospitals Association commissioned a research project on aspects of Private Hospital use and financing by Professor C.A. Blyth, Professor of Economics at Auckland University, and presented his report as part of their extensive submissions.
- <sup>78</sup>Letter to me from Dr L.C.H. Averill, February 11, 1974.



CHAPTER 5: AVOIDING THE INEVITABLE

In the last two chapters I have tried to show, detail by detail, how the model I developed, does in fact, neatly fit with and explain events going on in the real world. Now I want to examine, more carefully, the consequences of the processes I have identified; in particular, what happens when the exit process continues to dominate the public sector.

#### THE CONSEQUENCES OF THE CONTINUING DOMINANCE OF EXIT.

The first and most obvious consequence is a flourishing private sector; doctors get richer, the reserves of medical insurance companies rise satisfactorily, and private hospitals make plans for expansion.<sup>1</sup> Because superior market power allows it to buy as many doctor services as it requires and market pressures lead to their efficient use, the private sector continues to offer better services than the public sector in all of those areas where they compete. Consequently, those who can afford exit are anxious to guard their privileged position; if governments should wish to diminish or end their present subsidy of exit they are likely to incur widespread public outcry. The more the private sector flourishes, the more difficult it is to restrict its activities.

The limits of private sector expansion remain unclear. The key question is: will expansion be confined to those specialties in which the public and private sectors currently compete ("vertical" expansion), or will it involve, as well, expansion into specialties in which the public sector now has a near or total monopoly ("horizontal" expansion)?

Earlier I argued that private sector expansion depends on the existence of public sector deficiencies. As well, I showed how the exit process works to enlarge any deficiency that appears. Thus, any quality lapse, in any public sector specialty, is likely to be translated into new business for the private sector. Small, perhaps random, quality lapses in those specialties in which the public sector currently has a monopoly or near monopoly, immediately open up the possibility of "horizontal" private sector expansion. Over time, if such lapses should occur, private sector expansion may penetrate all specialties up to the limits of the private sector's ability to buy and use efficiently the necessary equipment.

The second consequence of continuing exit is the deterioration of the public sector. In each of the specialties in which the public and private sectors compete, lapses in public sector quality will not lead to consumer pressure for remedy. Instead, consumer actions will work to worsen public sector quality by draining it of its resources. Thus, for any given level of resources in the public sector, whatever inefficiencies, mis-allocations or other bureaucratic pathologies that appear are likely to go uncorrected.

As well, perhaps in part because of the helplessness of the victims, an extremely unsubtle change in atmosphere accompanies shifts from the provision of service for the general public to the provision of services to the medically indigent only. Charity care, where ever it occurs, is not only almost always second rate (and sometimes dangerous) care, but as well is demeaning to the recipient.<sup>2</sup>

Public sector deterioration thus results from both the constant erosion of resources and the continuing uncorrected misuse of those resources that are available. Its human consequences include the likely humiliation of its users. How many public sector specialties will suffer this kind of malaise depends on the extent of "horizontal" private sector expansion; those specialties in which the public sector continues to enjoy a monopoly are likely to provide satisfactory service.

Overall, continuing exit works to increase the proportion of medical services distributed through the market and diminish the proportion distributed through the welfare state. In the market need is not a relevant criterion. Instead, access to medical care is determined by purchasing power; those able to pay more secure larger quantities of care, of better quality, than those paying less, regardless of medical need.<sup>3</sup> The resulting distribution of medical care follows closely the inverse care law: "The availability of good medical care tends to vary inversely with the need for it in the population served."<sup>4</sup>

Thus, the exit process is the mechanism which is currently, very quietly, revolutionising our arrangements for the allocation of medical care. It may still be true that,

Unlike overseas people self respecting freedom loving New Zealanders will never respect or tolerate a service which gives one type of service to the poor and another type to the well-to-do. [and that] Any scheme which savours of a poor man service, of charity which divides the people into two groups, those able to pay private fees and those unable to

do so; which differentiates in the mind of the doctor either consciously or unconsciously between patients, would be foreign to the ideals and aspirations of the government in particular and the people of New Zealand in general.<sup>5</sup>

Nevertheless, just such a system is being reinstituted in New Zealand.

#### WILL EXIT CONTINUE?

But will exit, in fact, continue? In Chapter 3, I set out the reasons for believing that it would. Thus, I argued that the potential for exit remains only partially tapped; that even if public sector performance got no worse, the development of new insurance schemes, the spread of employer subsidies and so on, would be enough to guarantee more exit. But in fact public sector performance is likely to get worse; thus a much larger number of people will have reason to exit. As well, I argued, exit will not be halted by lack of private sector facilities; the existence of "slack" in the private sector, and the ready availability, either from government or private sources (especially the medical insurance industry), of sufficient funds for expansion, means that private sector waiting lists are unlikely to develop.<sup>6</sup>

But perhaps exit may still come to an end, for reasons other than those I have examined so far. Because continuing exit (regardless of whatever else happens), spells the ruin of the public sector, such a possibility deserves further examination.<sup>7</sup> I showed earlier that those who can both exit and voice will choose exit when both of the following conditions occur:

1. the private sector provides sufficiently better care than the public sector to make exit worthwhile.
2. the cost/effectiveness of exit is superior to the cost/effectiveness of voice.

If exit is to end, either or both of these conditions must no longer hold.

For all of the reasons outlined in Chapter 3, I have no doubt that the private sector will continue to offer "no waiting" service, in what are likely to become increasingly pleasant and well staffed surroundings. Thus, the present gap between public and private sector service which makes exit "worthwhile", will not be closed by private sector decline. But perhaps improvement of the public sector will occur instead. After all, the present government, while continuing to subsidise exit, is also committed to,

upgrade the public hospital system to a situation where a comprehensive service is available to all, irrespective of financial circumstances.<sup>8</sup>

For the public sector to be "upgraded" enough to stem exit, the very least requirement is that it offer "no waiting", or nearly "no waiting", service.<sup>9</sup> Nothing the present government has done, or has promised to do, will bring about such an outcome. I have already shown that, despite the recent hike in government spending on hospitals, the real increase in amount spent per capita is small. Even if all of this increase were spent in attempting to improve

service in "waiting list" specialities (clearly it will not be), not much difference would occur. This is not simply because the amount of money is small compared with the problem it has to solve.

In fact, flooding the public sector with extra finance, a tactic not yet tried by New Zealand governments, may still not make much difference to public sector performance. As long as resources are allocated and used inefficiently, a great deal of money will be required to make quite small differences in performance.

The present Minister of Health recognises the conflict of interest, besetting doctors who operate in both the public and private sectors, as a major cause of inefficiency in "waiting list" specialties.<sup>10</sup> A key passage in the Minister's 15 point plan to reduce waiting lists required that,

In general hospitals of 250 beds or more, boards should develop full-time surgical units and appoint a full-time director of surgery. Until this is done no more part-time appointments of surgeons are to be made except with my approval.<sup>11</sup>

A year later the Minister still believes,

there should be more full-time medical appointments in hospitals. He intends to explore ways of strengthening the relative positions of these doctors with their part-time counterparts.<sup>12</sup>

That such a policy should be needed at all, reflects the fact that, at present, doctors in "waiting list" specialties find full-time appointments unattractive. As

exit inflates the private sector demand for their services, they are likely to find them even more so. At the same time, in any trial of strength over the "full-time" issue, doctors appear in an enviable bargaining position. The point is nicely made in this report of a meeting of the North Canterbury Hospital Board in February, 1974:

The Minister of Health (Mr Tizard) also received some gentle criticism for his policy on part-time staff. The Board employs many surgeons part-time, but the Minister preferred appointments to be full-time, Dr Berry said. [ Dr Berry is the Medical Superintendent-in-Chief of the North Canterbury Board ] "An example of the need for this was in plastic surgery," he said. "Cases involving cleft palates and hare lips have not been through the outpatients for many years. These are all through private referral. Without this field in private practice there is not enough work for a plastic surgeon to do full-time, and so some of them leave. We need a plastic surgeon, but he needs his private practice to be fully occupied. If we can't take him on a part-time basis, we might miss out altogether," said Dr Berry. The Board agreed to press for continuation of the part-time appointment system.<sup>13</sup>

Thus, even if Mr Tizard should find, "ways of strengthening the relative positions of these (full-time) doctors" (and he has not, so far), full-time positions are unlikely to attract "waiting list" specialists.<sup>14</sup> In fact, in the face of already rising private sector demand, Mr Tizard's immediate problem is simply to retain the present level of services provided by part-time specialists.<sup>15</sup>

The logic of this argument rests on two assumptions. The first, that private sector demand for specialist services will rapidly increase, I have given a great deal of evidence for. A second and equally crucial assumption, is that the number of specialist services available will



continue to be too few to satisfy demand for them. That this is presently so is attested by the absence of unemployment among specialists, together with the occurrence of long waiting lists in the public sector. But such circumstances may not always prevail. The first class of the Auckland Medical School graduated in 1973; the student intake at Auckland is to be raised from the present 60 to 128 in 1977 and 200 in 1981. At the same time the intake at Otago has been increased from 120 in 1971 to 150 in 1972 and then, it is planned, to 200 in 1975. And currently, migration is adding to the numbers of doctors available (for the years ending 31 March 1971, 1972, and 1973, respectively net gains of 87, 90 and 79 doctors were recorded).<sup>16</sup> Although such estimates are fraught with uncertainty, the New Zealand doctor to population ratio should steadily diminish over time.<sup>17</sup>

In such circumstances, will my second assumption still hold? It seems to me that it will. First, it takes a good deal of time to translate an increasing number of doctors into an increasing number of specialists; while the training of doctors takes five years, the training of specialists takes considerably longer than this again. Whatever happens, neither the private nor public sectors are likely to be quickly swamped with the services of specialists.<sup>18</sup>

Second, the crucial question is not the number of specialist services available, but their allocation between the public and private sectors. As long as the private sector can get all of the services it requires and, as well, there is rapidly rising private sector demand, any increase in specialist services is likely to be absorbed by

the private sector. Only when all private sector demand had been satisfied will specialists seek public sector work.

Finally, while it is easy to imagine what a surplus of specialist services would be like, it is difficult to find real world cases. The United States, for example, has a heavy emphasis on "specialism" and a doctor to population ratio considerably lower than New Zealand.<sup>19</sup> At the same time it makes no pretence of providing good medical care for everyone; instead available medical resources are heavily concentrated on those who can afford them, leaving still unsatisfied demand among the poor. Even so, as the high prices American doctors command and their ability to avoid such niceties as house calls shows, it remains a sellers' market.<sup>20</sup> It seems difficult to satiate a society with medical services.

For all three reasons, it appears that my second assumption, that the number of specialist services available will continue to be too few to satisfy demand for them, will continue to hold in the foreseeable future. Thus, the public sector will not be bailed out, either by the present government's wish to make only full-time appointments, nor by the decision of the previous government to increase the output of medical graduates.

The present government's last known card remains unplayed; Mr Tizard proposes to publish a parliamentary white paper in July or August of 1974, setting out arrangements for the creation of regional health authorities. Exactly what is being proposed remains unclear. Nevertheless, the Director General of Health (Dr H.J.H. Middlestone)

has suggested that,

We would like to see the country divided into 14 or 15 regional health authorities, serving a minimum population of around 100,000 and a maximum of 450,000. [The authorities] would be something totally new and would cover all aspects of health services. We must break down the rigid barriers between hospital care, community care, public health, preventative medicine, and health education.

The main administration would be done by a quartet of the chief medical superintendent, chief nursing officer, board secretary and the medical officer of health. The authority itself would be made up of elected and appointed members (the Department of Health suggesting that the authority have 13 members, seven elected on a ward system and the other six appointed).<sup>21</sup>

As well, Mr Tizard has made it clear that he envisages that,

many of the functions of the Health Department will devolve on the new authorities [and that] responsibilities in health at present administered by local authorities would also be brought within the gambit of the regional bodies.<sup>22</sup>

Just what will happen to hospital boards remains unclear. Dr Hiddlestone suggested that,

Hospital Boards would probably remain as they were now, and would not conflict with the regional authorities,

while another, later story, suggests that,

... in recent speeches they (Mr Tizard and Dr Hiddlestone) have been talking about a wide-ranging reform which could replace hospital boards with all-embracing regional health authorities.<sup>23</sup>

Whatever final form regional authorities may take, it is already clear that their introduction is designed to implement two important changes. The first is the devolution of power from the national to the regional level; the amount of power over the allocation and administration of medical resources enjoyed at the local level will increase, while that held at the national level will decrease. The second is the concentration of administrative power within regions; presently dispersed responsibilities for the administration of health care will be brought together under the regional authorities.

Will regional health authorities improve public sector performance? Whatever happens, the effects of their introduction will be considerably delayed; Mr Tizard anticipates a three year period from the introduction of the white paper to the final drafting of legislation. Then, the most marked effect of reorganisation on public sector performance may come about indirectly through its impact on voice (a point I discuss below). Other than that, if the authorities successfully co-ordinate community health services, public sector performance may be improved by the more efficient recruitment of hospital patients; as well, administrative de-centralisation may allow better monitoring of local performance, increase the possibility

of innovation and so on. However, without more fundamental changes, regional authorities will make no difference to private sector erosion of public sector resources.

Thus, in the meantime it remains unclear what effects re-organisation will have on public sector performance. While everyone would like to think that re-organisation will work to improve the public sector, its benefits (such as they may be) will not be felt for some time.

For all these reasons, it seems most unlikely that public sector performance will sufficiently improve in the next few years to make exit no longer worthwhile. If exit is to be halted it will have to be because the second condition (that the cost/effectiveness of exit is superior to the cost/effectiveness of voice) no longer holds.

The first possibility is a rapid increase in the cost of medical insurance to a level where no more people can afford exit. Such an increase seems most unlikely; while the costs of hospital care have increased a great deal over the last decade, the cost of medical insurance has remained fairly low.<sup>24</sup> Competition between rival insurance organisations, government subsidy of the private sector and government and employer subsidy of insurance premiums should all contribute to keeping exit's price down. However, even if the price of medical insurance should rise substantially, the evidence provided in Chapter 3 suggests that few people would stop paying their premiums. Thus, exit is unlikely to be halted because of sharp increases in its cost.

The second possibility is a change in the cost/effectiveness of voice relative to exit; if voice should become increasingly effective then some of those anxious to

"do something", who presently choose to exit (or remain passive), may voice instead. To the extent that voice does work, then improvements in public sector performance should diminish the benefits of exit and so on.

In the absence of a major break through by a voice entrepreneur, it is clear that some change in institutional arrangements will be required to increase the effectiveness of voice. New Zealand governments, seeking to solicit and strengthen voice have often made such changes; in fact, the present Labour government has been particularly innovative in this regard. Its decision to set up the "Guardians of the Lakes" built the voice process into the heart of future decision making about Manapouri. Even more innovative, especially in its attempt to involve all members of the community, rather than simply the representatives of pressure groups in its deliberations, has been the Educational Development Conference.

Three years or more from August of 1974, if Labour should continue in office and if nothing else happens in the meantime, the creation of regional health authorities may do for voice something of what medical insurance is currently doing for exit. As New Left theorists and others have pointed out, the decentralisation of political power increases the probability of genuinely participatory democracy; i.e. it lowers the cost of voice.<sup>25</sup> At the same time, the concentration of administrative power at the regional level means that successful attempts to influence the regional authority will make real differences to the allocation and use of medical resources. Thus setting up regional authorities should work to encourage voice by

making it both easier and more effective.

But whose voice? Without knowing more about the details of the authorities' structure, still less its actual operation, only best guesses can be made. Mine is that the voice elicited will come predominantly from those who have exited, or have a vested interest in others exiting. Thus, the decisions made by the authority will come to reflect the needs and wishes of those who have exited, even more closely than would decisions made by a national government.

This guess rests on two observations. The first is the fact, that, for any set of people, exit harvests disproportionate numbers of those who both care most about the quality of medical care and have the most political resources. Or, to put it another way, those people most likely to be concerned that a regional authority "properly" allocate medical resources, and most able to influence this allocation, are also those who have the least personal reason to care about some public sector services. If voice is made easier and more effective by the setting up of regional authorities, it is their voice that will be most encouraged, and, if effective, their interests that will prevail.

The second observation rests on the central role doctors play in any decision about the provision of medical care. Doctors have good reason to care about what decisions are made; it is their incomes and conditions of work that are most affected by the outcomes. At the same time, the diffidence most laymen feel in making judgements about the provision of medical care, means that they rely heavily on

"expert" opinion; at present it is usually doctors who advise and often decide about medical matters in New Zealand.

Thus the profession's power to influence the allocation of medical resources rests on a unique combination of interest and ascribed expertise.

The lobbying of the Medical Association of New Zealand makes it clear that the majority of doctors favour the expansion of the private sector and are not overly concerned with the consequences for the public sector. Defence of public sector interests rests explicitly with the Minister of Health and his Department, not with the medical profession as a whole. In the present context administrative decentralisation, as in the creation of regional authorities, is likely to further strengthen the hand of those favourable to private sector expansion (i.e. M.A.N.Z.) at the expense of those defending the public sector.

Decentralisation makes effective voice at the local level much easier for doctors as well as others. At the same time, it results in the fragmentation of Health Department expertise which, at present, acts as an important counterweight to the profession's considered judgements. As well, increasing the number of decisions taken at the local rather than the national level, makes it easier for an intense minority (which doctors in this situation certainly are) to "hamstring" decisions that run counter to their interests.<sup>26</sup>

Happily for the private sector, the interests of the medical profession and those who have exited, nicely coincide in defence of private sector interests. Thus those who are likely to feel least diffident about



challenging the profession's options are also likely to be most in harmony with them.

All of this is, of course, pure guess-work. However, its plausibility suggests that the introduction of regional authorities may, in the present context, lead to consequences which are clearly not desired by the Minister of Health. In particular, strengthening voice may lead to decisions which hasten rather than slow public sector deterioration.

So far I have concentrated almost entirely on the possibility of consumer voice defending the public sector against deterioration. But other voices may perform the same function. In education, for example, employees' associations, the New Zealand Educational Institute and the Post Primary Teachers Association, have been in the forefront of attempts to win more resources from government. As well, they have defended public sector education tooth and nail against private sector encroachment; slogans such as, "no state aid for private schools" have long been rallying cries among teachers. Perhaps such voices may be heard in defence of public sector medical care as well.

The two most obvious sources are doctors and nurses. But the interests of doctors, in general favour the expansion of the private sector, as I have shown. The official voice of the medical profession has never been used in defence of public over and against private sector interests. Individual doctors are of course another matter. Some of them clearly stand to gain nothing from private sector expansion (for example those in "higher" specialties and those employed in Medical Schools; these

two categories often overlap) and some are less enamoured than others of the virtues of the free market distribution of medical care. Nevertheless, individual doctors have not generally been a source of voice; the slogan "no state aid to the private sector" apparently stirs only private sector defenders among the medical profession.

Nurses constitute a second possible, non-consumer source of voice, in the defence of the public sector. Such voice is not without precedent. I have already shown how the use of voice by psychiatric nurses encouraged the setting up of the Royal Commission on Hospital and Related Services. As well, the position of nurses would appear to be more closely analogous to that of teachers than the position of doctors appears to be. Nurses, like teachers, do not stand to gain anything from private sector expansion. But in fact, for whatever reason, nurses have not used their voices in defence of the public sector. Nor do they seem likely to.<sup>27</sup>

By now it should be obvious why the issue of consumer voice has been the crucial focus of the study. If consumers fail to defend the public sector against private sector encroachment; if consumers fail to press for the remedying of public sector defects, then no one else will. But even if institutional changes (such as the introduction of regional authorities) make voice easier and more effective, the prospects for consumer voice, seeking to defend and improve the public sector, remain poor.

First, however much easier and more effective voice may become, it will still lack the immediate, guaranteed, effectiveness that exit now provides. It is probable that

for as long as exit is available in its present form, attempts to encourage voice will make little difference to the choices consumers make between the two options.

Second, in the present context, making voice easier may most encourage the voices of those who have already exited, or, as in the case of doctors, who benefit by exit. Their use of voice is unlikely to have the overall defence and improvement of the public sector as its first objective. Instead, voice will most likely be used to win increasing protection for, and subsidy of, the private sector services those who exit use, as well as ensuring generous public sector provision for those services not provided for by the private sector. Thus, arrangements that make voice easier and more effective may, in fact, encourage further exit by depressing public sector performance in all of those areas where it competes with the private sector.

Overall, the chances that exit will be halted by a change in its cost/effectiveness relative to voice seem slim. Heavy increases in the cost of exit are unlikely; if increases should occur few of those who have exited, or plan exit will be discouraged. At the same time, even if institutional changes should make voice easier and more effective, consumers are still likely to prefer exit to voice. Such changes, far from diminishing exit, may instead lead to decisions that hasten public sector deterioration. Finally, if consumers fail to use voice to defend and improve the public sector, no one else seems likely to.

## SUMMARY.

If exit continues, our present arrangements for the distribution of medical care will be quietly revolutionised; medical care will be increasingly distributed on the basis of ability to pay, rather than need. That exit will, in fact, continue seems likely; neither present attempts to close the quality gap between the private and public sectors, nor institutional innovations that make voice easier and more effective seem likely to diminish it.

Thus, unless some new factor intervenes, the legislation providing for the welfare state distribution of medical care is, de facto, being repealed. In the present circumstances repeal raises no great clamour; the passing of a key welfare state provision is marked only by the voices of some few ideologues.

## WILL ANYONE CARE?

At present, the accumulation of individual, unco-ordinated decisions to exit is bringing about a qualitative change in the provision of medical care. This fact does not mean that those who have or will exit prefer the replacement of the welfare state by the market distribution of medical care. Instead the very opposite may be true; everyone who exits may prefer a properly functioning welfare state system to a market system, yet paradoxically they choose the option which leads to the restitution of the market. How can this be?

The answer was suggested in a slightly different context in the first chapter. I showed that even if

consumers knew the consequences of exit for the public sector and believed these consequences to be undesirable, they are still likely to exit.

Thus, if I decide not to exit, I forgo the benefits of the private sector. At the same time my decision not to exit, even if I voice, is unlikely to make any difference to public sector performance. The public sector collapses, if it does, not because of my decision, but because many people decide to exit and many people decide not to voice. Thus, if I stay and everyone else exits, the public sector will still collapse. Alternatively, if everyone else stays and I leave, the public sector improves, a fact from which I benefit as much as those who have stayed. Thus, the decision not to exit means that I forgo the enjoyment of private sector care, but still contribute unappreciably to the improvement of the public sector. Because the logic is the same for each other consumer, my best strategy is always to exit, even although given the choice between the welfare state and the market distribution of medical care, I prefer the latter.

This renewed excursion into the logic of the commons' dilemma immediately raises an empirical question of crucial importance: how many New Zealanders, in fact, desire the replacement of the welfare state provision of medical care by a market system? Knowing that exit and a preference for non-market arrangements can logically "hang together", raises the possibility that the present revolution in the provision of medical care may be desired by few, or no, New Zealanders.

The evidence available is incomplete. No national referenda have been held on the question, no elections have been fought over it (at least since 1938, when the

proponents of the market solution were decisively defeated), nor, to my knowledge, have any surveys been conducted locally or nationally to sample public opinion on the issue.

Nevertheless, it is clear that some people will be unhappy with the change. First, and most obviously, all of those people who will directly suffer from the free operation of the inverse law of medical care, ("the availability of good medical care tends to vary inversely with the need for it in the population served"): i.e. the poor, old and chronically sick.<sup>28</sup> The increasing encroachment of the market means that those groups of people (about 20% or more of the population) needing medical care the most, will tend to get the least and worst available. They clearly will not be happy with an institutional change which dramatically compounds their present disadvantage.

As well, for one reason or another, a great many New Zealanders care about what happens to others worse off than themselves. Although equality, in the sense of giving everyone a "fair go", is not formally enshrined in a constitution, it remains a powerful community sentiment. The active component of the New Zealand egalitarian ideal, is the widespread belief that, whether or not Jack is as good as his master, he is at least entitled to decent housing, decent education, decent medical services and a decent income. Thus, unhappiness about the inequitable distribution of medical care through the market will not be confined to those who directly suffer from it.

More evidence is provided by a survey of public attitudes toward the provision of medical care conducted by Dixon and his associates in Dunedin and Auckland.<sup>29</sup>

(Although only a partial analysis of the Dunedin results has been reported so far, the Auckland results are apparently very similar).<sup>30</sup> Their questions did not bear directly on the issue of market versus non-market arrangements for the provision of medical care. Nevertheless they asked a number of questions of interest in the present context: first, whether those interviewed favoured private health insurance: 10% did, 79% did not and 11% made no comment. Second, about the degree of satisfaction with public hospital care: 58% reported complete satisfaction, 20% that they were well satisfied, 11% that they were fairly satisfied, 4.5% that they were a little dissatisfied and 1.0% that they were most dissatisfied (5.5% no comment). Third, the results of two questions dealing with where the respondents would like to be treated if they needed an operation for varicose veins or had a child with acute appendicitis are reported; for varicose veins 69% reported that they preferred public hospital treatment, 18% private and 12% had no preference: for appendicitis, 83% preferred public, 7% private and 10% made no comment.<sup>31</sup>

The question on medical insurance comes closest to asking people whether or not they favour market encroachment in the provision of medical care; quite clearly the overwhelming majority of those who have an opinion do not. As well, the questions dealing with public/private preference again show a widespread preference for public sector care; even for varicose vein operations which Dixon thought,

should give those wanting their tea on a silver tray a good opportunity for expressing their

belief in this type of service.<sup>32</sup>

Thus, even if the bulk of New Zealanders cared not at all about those the market fails to provide for, these results suggest that they would prefer non-market to market arrangements.

Experience from other countries suggests that familiarity with the market is unlikely to increase public affection for it. For example, the huge and increasing volume of litigation over medical care in the United States (usually argued to be the pre-eminent example of free market medical care) suggests a high level of consumer dissatisfaction.<sup>33</sup> Similarly, legislation planned, and in some cases already passed by Congress, seeks to limit and sometimes supplant existing market arrangements, apparently in response to widespread consumer dissatisfaction.<sup>34</sup> And of course it was New Zealanders own direct experience of the working of market arrangements that led to the existing welfare state legislation. Thus, people not now persuaded of the virtues of market distribution of medical care, are unlikely to change their minds after experience of its operation.

Finally, there is the key fact that no New Zealand political party has gone to the electorate pledged to dismantle, piece by piece, the welfare state provision of medical care. Despite government subsidy of the private sector (which has in fact worked to undermine the public sector), the issue of market versus non-market provision of medical care has been dead since at least the 1940's. Clearly no political party has felt that public advocacy of



a return to free market arrangements would win them votes.

Thus, the available evidence suggests that the great majority of New Zealanders do not desire the replacement of the welfare state provision of medical care by a market system. Instead, if it was in their power to bring it about, they would choose an efficiently operating public sector, offering high quality care without waiting lists. Lacking such power they continue to exit.

It is now apparent that we are, all of us, locked into a tragedy:

the essence of dramatic tragedy is not unhappiness. It resides in the solemnity of the remorseless working of things ... This inevitableness of destiny can only be illustrated in terms of human life by incidents which in fact involve unhappiness. For it is only by them that the futility of escape can be made evident in the drama.<sup>35</sup>

The seeds of the present tragedy lie in the decision of the first Labour government to allow the private sector to continue and to subsidise its operation. As long as the private sector existed, dissatisfaction with public sector services and the logic of incremental decision-making led Labour and National governments to encourage exit; from the early fifties the private sector began to flourish. Finally, the introduction and continuing success of medical insurance, raised the real possibility that almost all of us could exit. Paradoxically, the preservation of "freedom of choice" in hospital care impells us to actions whose collective outcome few of us would choose.

In the real world, scripts are always partially ad libbed. Thus, spelling out the nature of the tragedy men's

actions bring about, is not necessarily a cruel intellectual affectation, adding foreknowledge to inevitability. Instead it raises the possibility that men can and will act collectively to avoid outcomes that none of them desire. Knowledge provides both a reason to search for social innovations promising solutions and a reason for their acceptance.

Already it is clear that any successful solution to the problem posed by the dissolution of welfare state medical care will have two characteristics; first it will be a collective solution, collectively decided and collectively imposed. If individual actions, spurred by an individual calculus of value, result in tragedy, only all of us agreeing to desist from the action will prevent it. Because a solution requires the co-ordination of the actions of all New Zealanders, only the national government can arrange its implementation.

Second, the solution chosen will have to promise that the public sector will, in fact, operate efficiently, offering high quality medical care without waiting lists. Otherwise it will be politically untenable, raising the outrage of those increasing numbers of people whose sacrifice of present privileges it demands.

#### WHAT KIND OF SOLUTION?

By now the answer to the question, "What kind of solution?", should be fairly obvious. Exit spells the ruin of the public sector. Eventually it drains the public sector of its resources of finance and personnel; in the

meantime it ensures that public sector resources remain inadequate, misallocated, and inefficiently used. Attempts to prop up the public sector without halting exit are, I have argued, doomed to failure; either they make little or no difference or they work to make things worse.

At the same time, it is clear that attempts to halt exit without changing the context in which it occurs will prove equally fruitless. For example, the use of policies that dramatically increase the cost of exit by removing private sector subsidies, taxing medical insurance organisations, or by other means, is unlikely to benefit the public sector. Those newly denied the privileges exit brought them will be outraged. Their likely resort to voice will be aimed, not at improving the public sector, but at the much simpler task of re-instituting their access to the private sector benefits they previously enjoyed.

They will be supported, obviously, by the medical insurance organisations and the bulk of the medical profession. They will also be supported by the plain logic of the situation; denying a substantial number of people exit, in the absence of other changes, will result in the further overloading of public sector facilities. At the same time, private sector facilities, from whose efficient use the whole community could benefit, will be increasingly under-utilised. No government is likely to pursue such a policy.

Incremental changes which seek to halt exit, either by bolstering the public sector, or by making exit more difficult, will provide no one with an efficient public sector offering high quality care without waiting lists.

Halting public sector decay requires a single, simple, policy innovation that makes a qualitative change in arrangements for the provision of hospital care: the introduction of a "responsive" public sector monopoly.

#### WHY MONOPOLY?

Three questions immediately arise: why monopoly, what kind of monopoly, and how can monopoly be responsive? The answer to the first is straight-forward. The creation of a public sector monopoly in hospital care builds in voice and prevents the loss of personnel and finance. For consumers anxious to "do something" about the care they receive, the absence of a private sector means either that they voice or remain passive; the exit option disappears. Similarly doctors sink or swim with the public sector. Either they remain passive, or they channel their considerable voice, energy and, most important, expertise, into getting more of what they want from the public sector.

Thus creating a public sector monopoly sets up the possibility that things going wrong in the public sector will trigger off a process that leads to their repair rather than, as in the exit process, their further exacerbation. Building in doctors' voice is of crucial importance in this process; unlike consumers, doctors are in constant contact with the institutions responsible for medical care; they have a great deal of expertise with which to judge what is going on; and because their livelihood and professional responsibility is at stake, they have the most pressing reasons to voice. Usually the interests of doctors will coincide

with those of quality conscious consumers, especially given the concept of professional responsibility that is likely to arise in the absence of a private sector. Thus, just as the burden of monitoring educational developments is borne largely by teachers' organisations, so doctors are likely to alert quality conscious consumers to unsatisfactory occurrences in the public sector. The case for public sector monopoly rests therefore, on the fact that monopoly arrangements alone guarantee the two minimal requirements of an efficient, high quality, public sector: that public sector resources remain intact and that errors in public sector operation lead to processes likely to bring about their correction.

#### WHAT KIND OF MONOPOLY?

The second question is, what kind of monopoly? My proposal is that the public sector be extended (minimally) to include all those private hospitals providing medical and surgical beds. Thus all New Zealanders requiring medical care have equal access to all of the community's available hospital beds.

This extension does not involve any change in the ownership or administration of private hospitals; instead the public sector undertakes to pay the full amount of private hospital patients' fees; at the same time, private hospitals give up the right to, themselves, recruit patients. The resulting variety in styles of managing and owning within the public sector now becomes part of a carefully controlled experiment aimed at testing the most efficient and medically

satisfactory way of arranging hospital administration. Is it better to centre administration on larger units or on smaller ones and so on? The best practices should obviously be extended throughout the public sector.

As well no change is made in the present arrangements for providing medical services, except that the public sector now pays the bill. Patients still make their own arrangements with doctors of their choice, and doctors still receive the same fees in the same circumstances as formerly. Again the practice becomes part of an experiment whereby different ways of arranging doctor payments and the doctor-patient relationship are compared. If the private sector practice results in large savings in the number of days patients spend in hospital (as it appears to) and/or a large increase in the satisfaction of both consumers and doctors (as it appears to), then the scheme should obviously be extended right through the public sector.

The benefits, both in the short and the long term, of this kind of public sector monopoly are obvious. In the short term, all New Zealanders gain access to the extremely efficient and still under-utilised beds provided in what is, at present, the private sector. At the same time a major source of organisational "slack" in the public sector, the public-private split, is eliminated by simple fiat; public sector efficiency should soon approach present private sector levels. Waiting lists should show real decline within a very short period of time. In the long term, building in voice and experimentation with different methods of providing hospital services should lead to a hospital system increasingly satisfactory to doctors,

administrators and patients.

But these are collective benefits accruing equally to all New Zealanders. Fortunately, or unfortunately, the political feasibility of proposals is determined not by the collective benefits they provide, but by the selective costs and benefits accruing to interested groups. The first such group are those who own and administer private hospitals, either for profit, or as a community charity. Those who provide hospital care for profit should, according to the ethics of the market-place, be quite indifferent to the move, so long as they can be sure that their income will not diminish in future. That is not difficult to arrange. Those providing private hospitals as a charitable endeavour should positively welcome the move; now their charity can be extended to those who need it, as well as those who can afford it. Thus pleasing private hospital owners should be straight-forward.

The second interested group are doctors. The proposal does not involve any immediate change in the way they organise their medical practice, nor in their relationship with clients, save that in the "private" sector, the ultimate source of fees becomes the state. However, it is consumer choice that still decides the allocation of fees between doctors. Thus, the system would work just as the present medical insurance arrangements do, except that the state would meet all of the patients' medical costs, rather than just a percentage of them.

The introduction of arrangements involving essentially "no change" for doctors should not antagonise the medical profession. However, doctors are likely to have quite

legitimate fears about the future consequences of public sector monopoly; any feasible proposal for change must include provisions for allaying their anxiety. Minimally, doctors must be able to expect that the arrangements for making monopoly "responsive" will grant them a powerful voice in any future decisions about the provision of medical care. As well some other provisions, for example, a guarantee that fees will keep pace with inflation, may be needed to win doctors' acquiescence. Nevertheless the task does not seem too difficult.

The third interested group are consumers. Consumers are of two kinds; those who would normally escape public sector waiting lists by going to a private hospital and those who would normally wait. The latter group, which still comprises the great majority of New Zealanders, should welcome the proposal enthusiastically; the benefits of better public sector performance accrue directly to them.

The reactions of the former group, those who at present are users or potential users of private hospital facilities, are likely to be ambivalent. Under the present proposal they will retain, I imagine for good, their present right to choose which hospital they go to and who their doctor will be. Thus the principal of, "freedom of choice", will not be impinged on. As well, most of them are likely to welcome a thorough going improvement in public sector performance.

On the other hand, if some waiting lists remain, despite public sector improvement, private hospital users may object to losing their previous right to buy in at the top of the list. I suspect that such objections will not



win a sympathetic audience; the defence of naked market privilege sounds much less attractive than the present defence based on the principle of, "freedom of choice". Thus I expect that the overwhelming majority of consumers will welcome the proposal; including many of those who now have, or plan to take out, medical insurance.

The last interested group are the employees of medical insurance organisations. Seeing that the proposal's adoption means the end of their livelihood, it is difficult to imagine how they could be pleased with it. However, there is every reason to minimise the personal costs involved; employees should be given help in finding new jobs and compensated generously for any loss of income that they should suffer. The assets of the organisations can easily be returned to the policy holders who provided them.

Overall, the proposal is likely to be generally acceptable to all of the groups affected, except, of course, those who work for medical insurance organisations. However, one possible further bar to its adoption is cost. How much is such a proposal likely to cost tax payers?

The answer appears to be not very much more, if any more than at present. The state, quite apart from other subsidies to the private sector, currently provides between 40% and 50% of the income of private medical and surgical hospitals in the form of patient benefits: for the year ending 31 March 1972, patient benefits amounted to \$2,814,000 or 43% of the total income of these hospitals.<sup>36</sup> For an additional \$3,747,000 (approximately 1% of the allocation to hospital boards for 1973-74 and considerably less than the \$5 million that hospital boards were unable to spend

from their allocation for 1972-73) the state could have provided the entire income of all the country's private medical and surgical hospitals in 1972. Such a reform is unlikely to burden the tax-payer.

But this leaves doctors' fees unpaid. It is impossible to estimate exactly how much such fees will amount to: assuming that the average operation in a private hospital costs \$200 in doctors' fees, then the total for 1972-73 amounted to about \$10.5 million (or about 4% of the 1973-4 allocation to hospital boards).<sup>37</sup>

Against this relatively small amount must be set the gains expected in public sector efficiency in the absence of a private sector; in particular government dollars spent in future to repair public sector defects can be expected to provide a maximum return. However, even if the amount required was large and no great increase in efficiency could be expected, it is still unlikely that the proposal would be barred because of its cost; the continuing exponential growth in the medically insured suggests that a large number of New Zealanders are prepared to pay more, if they are guaranteed prompt, high quality hospital treatment.

Overall the proposal should result in immediate collective benefits accruing, at little or no cost, to the whole community. It is flexible enough to accomodate the requirements of all of those groups who might be able to veto its adoption, and is likely to be welcomed by the overwhelming majority of medical care consumers.

## HOW CAN MONOPOLY BE MADE RESPONSIVE?

The last question is how monopoly can be made responsive; in other words how to arrange public sector services so that they provide the maximum consumer satisfaction at the minimum cost. The answer is essentially pragmatic: the best arrangement is the one that works the best (by their fruits, you shall know them). Because any set of arrangements aimed at encouraging efficiency tends to lose its "bite" over time, no formula is likely to provide a permanent solution to the problem.<sup>38</sup> My concern here is not to spell out what kinds of arrangements should be made, but to outline how the concepts of exit and voice can suggest some ways of approaching the problem.<sup>39</sup>

A major sub-plot in the present drama has been the argument that the appearance of voice in the public sector will work to get things "fixed up". Creating a public sector monopoly has the effect of locking in the potential agents of voice; the remaining problem is how to encourage its use and make it more effective. I have argued that political and administrative decentralisation, as implied in the idea of regional medical authorities, is a key mechanism for promoting voice. Administrative decentralisation opens up the possibility of adapting services to local needs; political decentralisation opens up the possibility of local groups making considerable differences to local services through the use of voice. At the same time, the introduction of real political accountability of the members of regional authorities to the wards they represent, encourages members to solicit and listen to their constituents'

voices.

A second, parallel mechanism for encouraging voice, is the introduction of a regional medical ombudsman, whose task it would be to investigate the complaints of individuals about poor medical service. But, whatever arrangements are decided on, monopoly can be made more responsive by strengthening voice.

Voice remains the only mechanism available to ensure that medical care gets its share of resources, vis a vis, other community needs; it is also the mechanism likely to be used most in determining the allocation of available resources within the different sectors of the medical care system. However, it remains a messy way for consumers and others to get what they want; it requires those concerned to pay close attention to the service they receive, and often requires considerable co-ordination of effort if it is to work. It seems least useful in dealing with situations like the following: first, the need of individual consumers to make some immediate difference to the service they personally are receiving; second, the collective need of tax-payers to ensure the most efficient day to day use of the resources allocated to each sector of the medical care system.

Here the introduction of market mechanisms (including exit in new guise) can be used to supplement voice and further increase the responsiveness of monopoly. Two examples of such arrangements are the introduction of consumer vouchers for the payment of doctors and the use of "performance" contracts. Writing about public schools, Milton Friedman has argued that their sloppy performance is brought about by

the difficulty consumers have in rewarding them for good performance and punishing them for bad. He suggests that if consumers were issued with vouchers redeemable for education at any school, and that schools depended on these vouchers for funding, then competition between schools for custom would ensure the best use of available resources.<sup>40</sup> A similar arrangement could be made with regard to the employment of doctors by patients; if the choices patients make determine doctors' incomes, doctors may best cater for patients' needs.

Another kind of market arrangement, this time aimed at bringing about administrative efficiency, is the introduction of performance contracts. Here an administrator undertakes to provide a service of a specified quality within specified cost limits; his success earns him bonuses while failure leads the diminishment of his salary.<sup>41</sup> Thus consumers are not dependent on voice alone for making monopoly responsive.

Voice and exit provide two basic mechanisms for bringing pressure for improvement to bear on those responsible for public sector service. They can be combined in a variety of ways by the use of different institutional arrangements; exactly what arrangements are used to make monopoly responsive will depend on the results of pragmatic experimentation.

## CONCLUSION.

I began by tracing the consequences for the welfare state provision of medical care of the introduction of

medical insurance. The key conclusions that I reached were first, that medical insurance was bringing about the de facto repeal of welfare state arrangements and second, that this outcome was desired by few New Zealanders. I then considered ways in which welfare state arrangements could be restored and improved, so as to reinstate the principle of, "to each according to his needs", as the central rule for the distribution of medical care. However the major thrust of my analysis lies not with the specific solution suggested here, but in the argument that unless some such solution is soon adopted, a major human achievement, will be "accidentally" wiped out by the exigencies of the market.

NOTES.

<sup>1</sup>I have no information on doctors' incomes. However Southern Cross almost doubled their reserves for the financial year ending 31st December 1973,

Southern Cross is of course a non-profit making organisation in that there are no shareholders and members are the only beneficiaries. But we do have to ensure that there are adequate reserves available to maintain the strong foundation I have mentioned, and that is why the entire surplus on the year's operations, amounting to \$239,525, has been added to the reserves which now total \$545,240.

(From the Report of the Chairman, Mr L.H.I. Watson, to the Annual General Meeting of the Southern Cross Medical Society on April 8, 1974. The Press, April 13, 1974). As well I wrote to the Secretaries of the two major private hospitals in Christchurch, asking them (among other things), "Are your facilities currently under pressure? Do you anticipate any major expansion in the next few years?". The one reply I got read:

Yes. Daily bed occupancy figures are at a high level. In the not too distant future it is hoped to provide additional accomodation for 20 - 30 geriatric patients.

<sup>2</sup>See for example, Raymond S. Duff and August B. Hollingshead, Sickness and Society (New York: Harper & Row, 1968); Alonzo S. Yerby, "Public Medical Care for the Needy in the United States", in M.W. Susser and W.Watson eds., Sociology in Medicine 2nd edition (London: Oxford University Press, 1971); pp.382-401; and David Mechanic, Public Expectations and Health Care, particularly pp.80-101.

<sup>3</sup>Odin W. Anderson identifies two polar types of health-service systems. In the first:

All health services would be completely tax-supported according to a graduated income tax so that the higher income families would pay more than the lower income families; all health services would be provided at no direct charge to anyone; all facilities would be owned by the government; all health personnel would be salaried; and all curative and preventative services, including immunisation, periodic physician examinations and so on would be available.

In the second, health services are:

completely supported by private funds in the open market. .... All the facilities, services and

personnel are established on a profit basis for those who wish to invest in them. There are no gifts or subsidies. Service is "sold" only to those who can and wish to pay for it at the going rates. There is no free care. The government could conceivably purchase care for its wards on an open-bid system. The hospitals need not be open all night or on weekends unless they consider it of competitive advantage to have a stand-by service like an all night filling station. Physicians can tailor their services to the market regardless of need or even type of disease that may be unprofitable to treat..

In New Zealand we are moving from a system more like the first type to a system more like the second. Odin W. Anderson, "Health-Service Systems in the United States and other Countries - Critical Comparisons" in M.W. Susser and W. Watson, Sociology in Medicine, 2nd edition, pp.213-233.

<sup>4</sup>The Inverse Care Law was formulated by Julian Tudor Hart. It neatly summarises a large amount of data accumulated from societies where medical care is distributed through the market (principally the United States) and where it is distributed through other mechanisms. Julian Tudor Hart, "The Inverse Care Law", Lancet.

<sup>5</sup>From the "Report of the National Health Insurance Investigation Committee", 4 September 1937, pp.11-12. In W.B. Sutch, The Responsible Society in New Zealand (Christchurch: Whitcombe and Tombs Limited, 1971) p.51.

<sup>6</sup>Those who have praised the market as a means of allocating medical care have noted particularly its responsiveness to consumer demands; the New Zealand private sector is unlikely to prove an exception. For example see, James M. Buchanan, "The Inconsistencies of the National Health Service", in James M. Buchanan and Robert D. Tollison, eds., Theory of Public Choice (Ann Arbor: The University of Michigan Press, 1972) pp.27-95; Michael H. Cooper and Anthony J. Culyer, The Price of Blood; D. S. Lees, Health Through Choice. Already private hospitals have approached Southern Cross about financing expansion; so far Southern Cross has refused, arguing that the matter is a government responsibility. (See, Southern Cross, Submissions to the Board of Health Committees Inquiry; p.10). However, in the absence of government assistance, it is likely that the medical insurance companies would give assistance to the private sector; their very existence depends on the continued satisfactory functioning of private hospitals. In this regard Southern Cross's rapidly mounting reserves are of special interest.

<sup>7</sup>Unless no scarcity of resources existed; in this utopian situation, unlimited exit is perfectly compatible with high quality public sector care.



<sup>8</sup>Press Statement by the Minister of Health Hon. R.J. Tizard, on Report on Private Hospitals, 26/3/74 (mimeo.) p.1. Other, like statements, can be found in most of Mr Tizard's speeches.

<sup>9</sup>Cf. Chapter 3 where I show the major reason for dissatisfaction with the public sector is the fact of having to wait.

<sup>10</sup>In reply to a question in the House from Mr C.R. Marshall (Labour, Wanganui), the Minister of Health, Mr Tizard stated, that he,

was aware of the conflict of interest where a consultant with a part-time appointment to a public hospital was also engaged in private practice, particularly where he had access to a private hospital. It was for this reason that the government committee on health recommended as part of the policy to reduce hospital waiting lists, that there should be full-time directors of surgery at hospitals with more than 250 beds and that no more part-time surgical appointments should be made to public hospitals. There was evidence from at least three areas - Wanganui, Auckland and Taranaki - to support Mr Latimer's contention [that] so long as consultants are employed in public hospitals on a part-time basis, they are unlikely to pursue policies in their salaried hospital role which could jeopardise that part of their living they derive from fees in private practice.

The Press, November 16, 1973.

<sup>11</sup>The Otago Daily Times, April 26, 1973.

<sup>12</sup>The Christchurch Star, April 27, 1974.

<sup>13</sup>The Press, February 28, 1974.

<sup>14</sup>The only possible way would seem to be for the public sector to pay better than private sector salaries. However this is likely to be difficult. First, private sector work allows specialists heavy tax deductions; thus the salary paid by the public sector would have to be considerably higher than in the private sector, because of the difference in net income after tax. But even so the deal is likely to be unattractive. One of the principal attractions of the private sector is that doctors can raise fees as they wish; whereas government approval is required in the public sector.

<sup>15</sup>Cf. the information given in Chapter 4, showing the loss of services that the public sector is currently experiencing, in areas where the most exit occurs.

<sup>16</sup>Department of Health, "Projection of Medical Manpower

Needs to the Year 2000", (Department of Health 1973, mimeo).

- 17 It is notoriously difficult to make predictions about medical manpower requirements. The main prognostic difficulties are:
- 1.1 Changes in the level of demand for items of service by the public.
  - 1.2 Changes in the incidence of disease.
  - 1.3 New techniques and therapeutic methods.
  - 1.4 Changes in the organisation of health services, e.g. the division of labour between the allied health professions.
  - 1.5 The economic situation.
  - 1.6 Changes in attitude to immigration and emigration.
  - 1.7 Changes in teaching methods and attitudes to post-graduate education. This affects the number of medical teachers required as well as the productive time of those being taught.
  - 1.8 Changes in attitude to the normal hours and conditions of work, holidays, study leave and the like.
  - 1.9 Unreliability of population projections.

Against this background of uncertainty we must plan for the future. Ibid.

- 18 I have ignored the possibility of emigration; if New Zealand's most skilled doctors find it difficult to find employment here, they are likely to leave the country long before the prospect of "swamping" occurs.

- 19 The World Health Organisation, World Health Statistics Annual 1969 (published 1973) gives the doctor to population ratio of the United States as 1:650 (cf. Israel 1:410, U.S.S.R. 1:430, Federal Republic of Germany 1:590) and that of New Zealand as 1:870.

- 20 David Mechanic, Public Expectations and Health Care.

- 21 From a report of the address given by Dr H.J.H. Middlestone, to the Medical Superintendents Association, Gisborne, March 7, 1974. The Press, March 8, 1974.

- 22 Christchurch Star, April 27, 1974.

- 23 The Press, March 8, 1974, and the Christchurch Star, April 27, 1974.

- 24 Cf. the Report of the Chairman, Mr L.H.I. Watson, to the Annual General Meeting of the Southern Cross Medical Care Society. 1974.

- 25 For a thoughtful account of some of the issues involved

in decentralisation see A.A. Altshuler, Community Control (New York: Pegasus, 1970).

<sup>26</sup>See J. Margolis, "Decentralisation and Urban Programs" in A.H. Pascal ed., Thinking About Cities (Belmont, Calif.: Dickenson, 1970).

<sup>27</sup>I wrote to the New Zealand Nurses' Association asking about the Association's policy toward the private sector. The National Secretary replied (letter dated, 24 December, 1973):

1. The Nurses Association does not have a written policy but our National Executive would agree that persons should have the right to choose whether they wish to enter a Public Hospital or pay for the additional benefits to be received from Private Hospital Care.
2. Again the Nurses Association does not have a written policy but generally it is not opposed to Private Medical Insurance Schemes.
3. The Nurses Association would agree that both part-time and full-time hospital specialists be employed by Public Hospitals.

<sup>28</sup>Julian T. Hart, "The Inverse Care Law".

<sup>29</sup>C.W. Dixon, "Public Attitudes Towards Medical Care in Dunedin", in J.S. Dodge ed., The Organisation and Evaluation of Medical Care (Dunedin: Dept., of Preventative and Social Medicine, University of Otago Medical School, 1970). pp.73-84.

<sup>30</sup>Interview with Professor C.W. Dixon, Dunedin, 26 April, 1973.

<sup>31</sup>Ibid.

<sup>32</sup>Ibid. p.83

<sup>33</sup>See for example, Richard M. Titmus, The Gift Relationship (London, George Allen & Unwin Ltd, 1970). pp.158-172.

<sup>34</sup>See, for example, Theodore R. Marmor with Jan S. Marmor, The Politics of Medicare, Library of Social Policy and Administration, (London: Routledge & Kegan Paul, 1970).

<sup>35</sup>A.N. Whitehead, quoted in G. Hardin, The Tragedy of the Commons, p.111.

<sup>36</sup>Reports by C.A. Blyth, New Zealand Private Hospital Association (Inc.), "Submissions to the Board of Health Committee on Private Hospitals, Part Three". p.28.

<sup>37</sup>The figure is arrived at by multiplying \$200 by 52,000 (approximately the number of surgical admissions to private hospitals in 1972-73. See Table 38, Chapter 3.).

<sup>38</sup>Hirschman, Exit, Voice and Loyalty, pp.120-126.

<sup>39</sup>Cf. the excellent article by Dennis R. Young, "Institutional Change and the Delivery of Urban Public Services", Policy Sciences, 2, (1971), pp.425-438.

<sup>40</sup>Milton Friedman, "The Role of Government in Education".

<sup>41</sup>Cf. the proposal for the reorganisation of the New Zealand Health Services made by J.S. Werry. See J.S. Werry, "Time for a Change?" New Zealand Medical Journal, October 10, (1973) pp.303-306.

APPENDIX 1: HOW THE SAMPLES WERE DRAWN.

DRAWING THE WAITING LIST SAMPLE, 11 and 12 JULY 1973.

### The Sampling Frame.

The Lindex file at Christchurch Hospital was used as the sampling frame. It lists the names of all those on the North Canterbury hospital board waiting list except for gynaecological and plastic surgery cases whose names are held elsewhere.

Getting on the waiting list: Requests for patients to be put on the waiting list are received from 3 sources:

- a. Outpatient clinics
- b. Consultants rooms
- c. General Practitioners (only in the case of patients requiring general surgery or treatment for varicose veins can G.P.'s put patients names directly on the waiting list; otherwise patients are given an appointment at the relevant outpatient clinic).

Patients are divided into urgent and general cases. Urgent cases ("any patient requiring surgery within 4 weeks" and similar medical cases) are "placed" immediately and given the earliest possible vacancy. They are not listed on the Lindex File.

General cases are subdivided into 4 groups and a different coloured Lindex strip typed for each:

- a. routine cases
- b. semi-urgent
- c. urgent
- d. readmissions (Those who have been discharged from hospital within the last 18 months; readmissions are also classified as routine, semi-urgent and urgent, a note being added to the strip if they fall into the latter two categories).

The strips are then placed in strict chronological order on the appropriate Lindex frame. The Lindex frames are sub-divided as follows:

- 1. Vascular and arterial surgery
- 2. General surgery (subdivided by surgeon concerned)
- 3. Varicose veins (subdivided by male/female)
- 4. Genito-urinary (subdivided by adults/children)
- 5. Ophthalmic (subdivided by surgeon)
- 6. Ear Nose and Throat (subdivided by male/female/child and by surgeon).
- 7. Orthopaedic (subdivided by male/female/child and by surgeon).

### The sampling Method.

I hoped to obtain 150 usable interviews. I drew a

sample of 200 names, deciding to err on the generous side because I expected:

- a. that some people would be too frail to be interviewed
- b. some people to have entered hospital before the interviewing was completed
- c. that the sampling frame would be imperfect.

I proceeded as follows:

1. Using the June 30 Waiting List Report, I calculated the number of names held on the Lindex File by subtracting Gynaecological (461) and Plastic Surgery (174) cases from the case total (3,569) to give the Lindex File total (Total A) of 2,934.
2. I stratified the sample by specialty, calculating the number required in the sample for each specialty from the % of cases in Total A that each specialty represented. Thus:
  - i) Vascular and arterial surgery represented less than half of 1% and was not represented in the sample at all
  - ii) General surgery represented 2% of Total A and thus 4 names in the sample
  - iii) Varicose veins represented 28% of Total A and thus 56 names in the sample
  - iv) Genito-urinary cases represented 3% of Total A and thus 6 names in the sample
  - v) Ophthalmic represented 4% of Total A and thus 8 names in the sample.
  - vi) Ear nose and throat represented 44% of Total A and thus 88 names in the sample
  - vii) Orthopaedic represented 19% of Total A and thus 38 names in the sample
3. By dividing Total A by the number of names in the sample (200) I calculated a sample interval of 14. I then drew at random a number between 0 and 14 (8).
4. Using the Lindex frames of each specialty in turn, I recorded the 8th name and then every 14th name thereafter until I had the required number of names from that specialty.

#### Points to note.

1. Where the person sampled did not have a Christchurch address I then took the name of the first person after him on the list who did have a Christchurch address.
2. A few people had specified that they wished to be admitted to hospital after July 1973. Because these people were not waiting at the time the sample was drawn, they were disregarded for sampling. On the three occasions when such a name was drawn the procedure outlined in 1. was followed.

## DRAWING THE SOUTHERN CROSS SAMPLE, 30 and 31 JULY 1973.

At the time the sample was drawn, Southern Cross had transferred the names of all individual and some group members (excluding company groups and some national associations) to a computer file. The remaining names were stored in a card index system, filed by the name of the company or association concerned and then listed alphabetically within this classification. (Some companies were however further subdivided by branch, and then the names arranged alphabetically within this classification).

The Computer file.

The computer file held 86,709 names (as of 31 May 1973). The estimated total membership was then 217,000: thus 40% of the total membership was listed on the computer file. The number sampled from the file was therefore 40% of the total sample number required (72).

Of the names on the file 11,220 are from Canterbury (excludes South Canterbury). Southern Cross uses 3.2 to 1 as an estimate of the ratio of the number of insured per policy for the names on this file. Thus the estimated number of policy holders from whom a sample of 72 names was to be drawn = 3,500. The sampling interval was then calculated by dividing 3,500 by 72 to give 48. I then took every 48th name until I reached the end of the file.

The Card Index file.

Because policy holders are not listed on this file by locality some difficulties arose. I proceeded as follows: the person in charge of the card file index room made up a list of all those organisations and companies whose Canterbury membership he estimated (after inspection) to be more than 100, (listing all organisations with a Canterbury membership would have required searching every card on the file). These organisations were divided into the following groups:

a. National organisations

In this category the Southern Cross employee provided the national membership figures of the organisation concerned. These were divided by 8, and then by 3, in each case. Dividing by 8, provided an estimate of the total Canterbury membership of the group concerned. (The ratio of 1 in 8 was taken from the percentage of Canterbury members on the computer file. The society's general manager, expected this ratio to provide an accurate estimate, because Canterbury is a "typical" area (i.e. like Wellington and Auckland) in its membership distribution). The ratio of 1 to 3 (cf. 1 to 3.2., the rule of thumb used for the computer file) is used by the society to estimate the number of those insured per policy



for the card file index. On this basis a policy holders total was estimated as follows:

<u>Organisation</u>	<u>Estimated number of Canterbury policy holders</u>
P.S.I.S.	500
N.Z.E.I.	208
N.Z.I.E.	113
Dental Assoc.	46
Arch. Assoc.	38
Police	46
Ancient Foresters	36
Total	<u>987</u>

b. Canterbury Companies

The estimates provided by the Southern Cross employee were divided by 3 to give the following:

<u>Company</u>	<u>Estimated number of Canterbury policy holders</u>
C.F.M.	367
Int. Harv.	100
Firestone	167
A.H.I.	233
Ballins	333
Ballantynes	100
Blackwell M.	85
Cant. Sub Contract	133
Borthwicks	17
Cant. Building Soc.	40
Chemist Guild	100
D.I.C.	83
G.U.S.	40
Insur. Instit.	67
Mosgiel Kaiapoi	133
N.Z. Refrig.	117
P.D.L.	67
P.G.G.	900
S.I.M.U.	83
Press	67
C.F.C.A.	83
Christ College	50
Farmers Gr. Disc.	600
M.A.N.Z.	133
Hamilton Perry	100
Haywrights	100
Lichfield	50
Millers	50
N.Z. Farmers Co-op.	100
Total	<u>4498</u>

c. National companies.

Southern Cross provided estimates of the total Canterbury membership for each company which were then divided by 3 to estimate the number of policy holders.

<u>Company</u>	<u>Estimated number of Canterbury policy holders</u>
U.E.B.	100
N.Z. News	100
Whitcombes	67
Gen. Foods	100
Est. Total	<u>367</u>

The estimated total number of Canterbury policy holders from the companies selected from the card index was thus estimated to be 5,852. Of this total I estimated,

- a. National Organisations to account for 17%
- b. Canterbury Companies to account for 77%
- c. National Companies to account for 6%.

Hence of the portion of the sample (108 names) to be selected from the card index:

- a. 18 to be drawn from the National Organisations cards
- b. 83 to be drawn from the Canterbury Companies cards
- c. 7 to be drawn from the National Companies cards.

A sampling interval was calculated of 1:54. I then proceeded to draw every 54th Canterbury name from each of the groups in turn. If the 54th name was not a Christchurch city address (e.g. Belfast) I took the next name back (53, 52, etc) until I found a Christchurch city address. This procedure yielded the following:

- a. for National Organisations 16 names were drawn
- b. for Canterbury Companies 43 names were drawn
- c. for National Companies 8 names were drawn.

By multiplying the number of names drawn by the sampling interval I then accurately estimated the total Canterbury policy holders in each group as follows:

a. National Organisations	=	864
b. Canterbury Companies	=	2322
c. National Companies	=	432
d. total	=	3618.

Hence the numbers required from each group can now be accurately calculated to be:

a. National Organisations	=	24%	=	26
b. Canterbury Companies	=	64%	=	69
c. National Companies	=	12%	=	13.

To make up the required number from National Organisations the first Christchurch name in each organisation was taken and in the case of the 3 largest organisation, the second Christchurch name as well.

To make up the required number from Canterbury Companies the first name in each company group was taken (excluding Lichfield and Millers; see note)

To make up the required number from National Companies the first Christchurch name in each company group was taken and the second name also taken in the case of U.E.B.

## NOTES.

<sup>1</sup> Lichfield names could not be included as they had not yet been entered on the card index. Millers cards did not have Christchurch home addresses. The one Millers card that was drawn was (following my standard procedure) traced back to a Christchurch home address card.

APPENDIX 2: INTERVIEW SCHEDULES, INSTRUCTIONS TO  
INTERVIEWERS AND LETTER SENT TO THOSE  
INTERVIEWED.

EVERYONE IS CONCERNED ABOUT GOOD MEDICAL CARE. WE WANT TO FIND OUT WHAT PEOPLE THINK ABOUT THE PRESENT SYSTEM AND WOULD LIKE YOUR HELP. THIS IS A SHORT QUESTIONNAIRE AND WILL NOT TAKE VERY LONG.

- 1a. FIRST.... ARE YOU (IS YOUR CHILD) PRESENTLY ON A PUBLIC HOSPITAL WAITING LIST?

☐ yes ☐ no

- 1b. HOW SOON WOULD YOU LIKE (YOUR CHILD) TO GO TO HOSPITAL?

- 1c. HOW LONG HAVE YOU (YOUR CHILD) BEEN ON THE WAITING LIST FOR? \_\_\_\_\_ (YEARS AND MONTHS)

- 1d. HOW MUCH LONGER DO YOU THINK IT WILL BE? \_\_\_\_\_ (YEARS AND MONTHS)

- 2a. HOW DO YOU FEEL ABOUT THIS WAIT? ARE YOU FULLY SATISFIED, REASONABLY SATISFIED, SOMEWHAT DISSATISFIED, VERY DISSATISFIED OR DON'T YOU CARE?

☐ Fully Satisfied  
☐ Reasonably Satisfied  
☐ Somewhat Dissatisfied  
☐ Very Dissatisfied  
☐ Don't Care

- 2b. WHY IS THIS? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 3a. IS THERE ANYTHING THAT PEOPLE LIKE YOU CAN DO TO INCREASE THE CHANCES THAT THEY GET INTO A PUBLIC HOSPITAL WHEN THEY WANT TO?

☐ yes ☐ no

- 3b. (IF NO TO 3a.) WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3c. (IF YES TO 3a.) WHAT IS THAT? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3d. (IF YES TO 3a.) HAVE YOU DONE ANY OF THESE THINGS OR DO YOU PLAN TO DO THEM?

☐

Have done some of these things.

(SPECIFY) \_\_\_\_\_

\_\_\_\_\_

☐

Plan to do some of these things.

(SPECIFY) \_\_\_\_\_

\_\_\_\_\_

☐

Have done none and plan to do none.

4. HAVE YOU OR ANYONE YOU KNOW WELL HAD ANY EXPERIENCE WITH PUBLIC OR PRIVATE HOSPITALS?

☐

Public only

☐

Private only

☐

Both

5a. IN GENERAL DO YOU THINK THAT PUBLIC HOSPITALS PROVIDE BETTER CARE THAN PRIVATE HOSPITALS, PRIVATE HOSPITALS PROVIDE BETTER CARE THAN PUBLIC, THERE IS NO DIFFERENCE OR THAT IT DEPENDS?

☐

Public better than private

☐

Private better than public

☐

No difference

☐

It depends

5b. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6a. IN GENERAL HOW DO YOU FEEL ABOUT THE STANDARD OF MEDICAL CARE IN PUBLIC HOSPITALS ONCE YOU GET INTO THEM? ARE YOU FULLY SATISFIED, REASONABLY SATISFIED, SOMEWHAT DISSATISFIED, VERY DISSATISFIED, OR DON'T YOU CARE?

- ☐ Fully satisfied
- ☐ Reasonably satisfied
- ☐ Somewhat dissatisfied
- ☐ Very dissatisfied
- ☐ Don't care

6b. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7a. IS THERE ANYTHING THAT PEOPLE LIKE YOU CAN DO TO IMPROVE THE STANDARD OF MEDICAL CARE IN PUBLIC HOSPITALS?

- ☐ yes      ☐ no

7b. (IF NO TO 7a.) WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7c. (IF YES TO 7a.) WHAT IS THAT? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7d. (IF YES TO 7a.) HAVE YOU DONE ANY OF THESE THINGS OR DO YOU PLAN TO DO ANY OF THEM?

- ☐ Have done some of these things  
(SPECIFY) \_\_\_\_\_
- \_\_\_\_\_
- ☐ Plan to do some of these things  
(SPECIFY) \_\_\_\_\_
- \_\_\_\_\_
- ☐ Have done none and plan to do none



8a. DO YOU INTEND GOING TO A PRIVATE HOSPITAL FOR THE TREATMENT OF YOUR (CHILD'S) PRESENT MEDICAL PROBLEM?

☐ yes ☐ no

8b. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9a. DO YOU HAVE MEDICAL INSURANCE OR DO YOU PLAN TO TAKE IT OUT?

☐ No insurance and no plans to take out

☐ No insurance but plans to take out

☐ Yes

9b. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10a. WOULD DOING ANY OF THE FOLLOWING THINGS MAKE ANY DIFFERENCE TO THE SERVICE YOU GET FROM PUBLIC HOSPITALS? COULD YOU TELL US IF YOU THINK IT WOULD MAKE A GREAT DEAL OF DIFFERENCE, SOME DIFFERENCE, NOT MUCH DIFFERENCE, NO DIFFERENCE AT ALL? (HAND CARD.)

10b. COMPLAINING TO THE HOSPITAL SUPERINTENDENT?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10c. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_

10d. COMPLAINING TO THE HOSPITAL BOARD?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10e. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

10f. COMPLAINING TO YOUR FAMILY DOCTOR?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10g. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

10h. COMPLAINING TO THE OMBUDSMAN?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10i. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

10j. WORKING THROUGH AN ORGANIZATION (e.g. CHURCHES, UNIONS, PLUNKET ETC.) TO IMPROVE HOSPITAL SERVICES?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10k. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

10l. WORKING THROUGH A POLITICAL PARTY TO IMPROVE HOSPITAL SERVICES?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10m. WHY IS THAT? \_\_\_\_\_

10n. DEMONSTRATIONS, STRIKES OR OTHER KINDS OF DIRECT ACTION?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10o. WHY IS THAT? \_\_\_\_\_

10p. COMPLAINING TO THE HEALTH DEPARTMENT?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10q. WHY IS THAT? \_\_\_\_\_

10r. COMPLAINING TO YOUR MP?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10s. WHY IS THAT? \_\_\_\_\_

10t. COMPLAINING TO A CABINET MINISTER OR PRIME MINISTER?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10u. WHY IS THAT? \_\_\_\_\_

10v. WRITING TO THE NEWSPAPERS?

☐ Great deal of difference

☐ Some difference

☐ Not much difference

☐ No difference at all

☐ Don't know

10w. WHY IS THAT? \_\_\_\_\_

11a. SUPPOSE THERE WAS NO WAITING LIST AND THAT THE STANDARD OF MEDICAL CARE AND THE COST WERE THE SAME, WOULD YOU PREFER TO BE IN A PRIVATE HOSPITAL OR IN A PUBLIC HOSPITAL, YOU WOULDN'T MIND, OR IT WOULD DEPEND?

☐ Private

☐ Public

☐ Wouldn't mind

☐ It would depend

11b. WHY IS THAT? \_\_\_\_\_

12. THE FOLLOWING ARE SOME WAYS THAT PEOPLE CAN TRY AND INFLUENCE THINGS IN GENERAL (RATHER THAN JUST HOSPITAL MATTERS). HAVE YOU DONE ANY OF THE FOLLOWING THINGS IN THE LAST 2 OR 3 YEARS?

12a. WRITTEN A LETTER TO A NEWSPAPER OR A MAGAZINE?

☐ yes ☐ no

12b. (IF YES TO 12a.) HOW MANY TIMES? \_\_\_\_\_

12c. CONTACTED A LAWYER ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12d. (IF YES TO 12c.) HOW MANY TIMES? \_\_\_\_\_

12e. CONTACTED YOUR M.P. ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12f. (IF YES TO 12e.) HOW MANY TIMES? \_\_\_\_\_

12g. CONTACTED A CABINET MINISTER OR THE PRIME MINISTER ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12h. (IF YES TO 12G.) HOW MANY TIMES? \_\_\_\_\_

12i. HAVE YOU WORKED THROUGH ANY ORGANIZATION (FOR EXAMPLE, A CHURCH GROUP, A UNION, PLUNKET ETC.) TO TRY AND INFLUENCE PUBLIC POLICY IN SOME AREA?

☐ yes ☐ no

12j. (IF YES TO 12i.) CAN YOU PLEASE SPECIFY? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

12k. CONTACTED THE OMBUDSMAN ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12l. (IF YES TO 12k.) HOW MANY TIMES? \_\_\_\_\_

12m. HAVE YOU TAKEN PART IN ANY DIRECT ACTION LIKE PROTESTS OR STRIKES?

☐ yes ☐ no

12n. (IF YES TO 12m.) CAN YOU PLEASE SPECIFY? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

13. DID YOU VOTE AT THE LAST GENERAL ELECTION?

☐ yes ☐ no

14. DID YOU GO TO ANY CAMPAIGN MEETINGS AT THE LAST GENERAL ELECTION?

☐ yes ☐ no

15. DID YOU VOTE AT THE LAST LOCAL BODY ELECTIONS?

☐ yes ☐ no

16a. ARE YOU A MEMBER OF A POLITICAL PARTY?

☐ yes ☐ no

16b. (IF YES TO 16a.) WOULD YOU DESCRIBE YOURSELF AS A VERY ACTIVE MEMBER, AN ACTIVE MEMBER, A FAIRLY INACTIVE MEMBER OR AN INACTIVE MEMBER?

☐ A very active member

☐ An active member

☐ A fairly active member

☐ An inactive member

17a. DO YOU BELONG TO ANY CLUBS OR ORGANISATIONS (FOR EXAMPLE, A TRADE UNION, A CHURCH GROUP, SOCIAL CLUB, P.T.A. ETC.)

☐ yes ☐ no

17b. (IF YES TO 17a.) CAN YOU PLEASE LIST ALL THOSE THAT YOU BELONG TO? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

18. WOULD YOU SAY THAT YOU WERE MORE, LESS, OR AS LIKELY AS OTHERS IN YOUR CIRCLE OF FRIENDS TO BE ASKED YOUR OPINION ABOUT SOCIAL AND POLITICAL ISSUES?

☐ more likely

☐ less likely

☐ as likely

19a. WHAT IS YOUR OCCUPATION? \_\_\_\_\_

19b. AND (IF A MARRIED WOMAN) THE OCCUPATION OF YOUR HUSBAND? \_\_\_\_\_

19c. CAN YOU PLEASE TELL ME YOUR AGE? \_\_\_\_\_ (YEARS)

19d. AT WHAT AGE DID YOU FINISH YOUR FULL-TIME EDUCATION?  
\_\_\_\_\_ (YEARS)

19e. DO YOU HAVE ANY FORMAL EDUCATIONAL QUALIFICATIONS (FOR  
EXAMPLE, MATRICULATION, A UNIVERSITY DEGREE; AN ACCOUNTANCY  
QUALIFICATION, A TRADE CERTIFICATE ETC.)?

☐ yes ☐ no

19f. (IF YES TO 19e.) WHAT ARE THEY? \_\_\_\_\_

19g. FINALLY, CAN YOU TELL ME WHETHER YOUR <sup>Family</sup> INCOME THIS YEAR WILL BE:

- ☐ less than \$2,000
- ☐ less than \$3,000 but more than \$2,000
- ☐ less than \$4,000 but more than \$3,000
- ☐ less than \$5,000 but more than \$4,000
- ☐ less than \$6,000 but more than \$5,000
- ☐ less than \$7,000 but more than \$6,000
- ☐ less than \$8,000 but more than \$7,000
- ☐ more than \$8,000 (specify)
- ☐ no answer/don't know (delete wrong one)

THANK YOU VERY MUCH FOR YOUR HELP.

Interviewer \_\_\_\_\_

Date \_\_\_\_\_

Length of interview in minutes \_\_\_\_\_

Please write here any comments which you feel could help with the  
interpretation of the interview \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EVERYONE IS CONCERNED ABOUT GOOD MEDICAL CARE. WE WANT TO FIND OUT WHAT PEOPLE THINK ABOUT THE PRESENT SYSTEM AND WOULD LIKE YOUR HELP. THIS IS A SHORT QUESTIONNAIRE AND WILL NOT TAKE VERY LONG. PLEASE ANSWER THE QUESTIONS AS FULLY AS POSSIBLE (USE THE BACK OF THE QUESTIONNAIRE IF THERE IS NOT ENOUGH ROOM UNDER THE QUESTION).

1a. FIRST, DO YOU HAVE MEDICAL INSURANCE?

☐ yes ☐ no

1b. (IF YES) HOW LONG HAVE YOU HAD IT?

\_\_\_\_\_ Years \_\_\_\_\_ Months

1c. DOES YOUR POLICY COVER SURGICAL AND MEDICAL BENEFITS OR SURGICAL BENEFITS ONLY?

☐ surgical and medical benefits

☐ surgical benefit only

1d. DO YOU BELONG AS AN INDIVIDUAL OR AS A MEMBER OF A GROUP?

☐ individual

☐ group

1e. HOW MUCH DO YOU PAY FOR THIS INSURANCE?

\_\_\_\_\_ Dollars per annum

1f. ARE YOUR PAYMENTS SUBSIDISED BY YOUR EMPLOYER?

☐ yes ☐ no

1g. (IF YES TO 1f.) WHAT PROPORTION DOES HE PAY?

\_\_\_\_\_ per cent

1h. DOES THIS INSURANCE COVER OTHER MEMBERS OF YOUR FAMILY?

☐ yes ☐ no

2. WHAT DO YOU SEE AS THE ADVANTAGES TO YOU OF HAVING MEDICAL INSURANCE?

---

---

---

---

---



3. SOME PEOPLE CHOOSE TO HAVE MEDICAL INSURANCE BECAUSE IT MEANS THAT THEY CAN GET INTO A HOSPITAL WHEN THEY NEED TO; OTHERS DO SO BECAUSE THEY FEEL THE STANDARD OF MEDICAL CARE IS BETTER IN PRIVATE HOSPITALS OR BECAUSE THEY WANT TO BE ABLE TO CHOOSE THEIR OWN SURGEON. IN MAKING YOUR OWN CHOICE HOW IMPORTANT WERE THESE THINGS TO YOU?

3a. BEING SURE OF GETTING INTO A HOSPITAL?

- ☐ not important at all  
☐ not very important  
☐ quite important  
☐ very important

3b. BECAUSE OF THE QUALITY OF MEDICAL CARE?

- ☐ not important at all  
☐ not very important  
☐ quite important  
☐ very important

3c. BEING ABLE TO CHOOSE MY OWN SURGEON.

- ☐ not important at all  
☐ not very important  
☐ quite important  
☐ very important

- 4a. AS YOU KNOW, SOME YEARS BACK MEDICAL INSURANCE DID NOT EXIST IN NEW ZEALAND AND MOST PEOPLE HAD TO RELY ON THE PUBLIC HOSPITALS (OR PAY IN FULL FOR PRIVATE TREATMENT). SUPPOSE THAT WERE STILL THE CASE, IS THERE ANYTHING THAT PEOPLE LIKE YOU COULD DO TO INCREASE THE CHANCES THAT THEY GOT INTO A PUBLIC HOSPITAL WHEN THEY WANTED TO?

- ☐ yes      ☐ no

4b. (IF NO TO 4a.) WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4c. (IF YES TO 4a.) WHAT IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4d. (IF YES TO 4a.) HAVE YOU DONE ANY OF THESE THINGS OR DO YOU PLAN TO DO THEM?

☐ have done some of these things  
(SPECIFY) \_\_\_\_\_  
\_\_\_\_\_

☐ plan to do some of these things  
(SPECIFY) \_\_\_\_\_  
\_\_\_\_\_

☐ have done none and plan to do none

5a. UNDER THE SAME CIRCUMSTANCES (HAVING TO RELY ON PUBLIC HOSPITALS) IS THERE ANYTHING THAT PEOPLE LIKE YOU COULD DO TO IMPROVE THE STANDARD OF CARE IN PUBLIC HOSPITALS?

☐ yes ☐ no

5b. (IF NO TO 5a.) WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5c. (IF YES TO 5a.) WHAT IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5d. (IF YES TO 5a.) HAVE YOU DONE ANY OF THESE THINGS OR DO YOU PLAN TO DO ANY OF THEM?

☐ have done some of these things  
(SPECIFY) \_\_\_\_\_

☐ plan to do some of these things  
(SPECIFY) \_\_\_\_\_

☐ have done none and plan to do none.

6. HAVE YOU OR ANYONE YOU KNOW WELL HAD ANY EXPERIENCE WITH PUBLIC OR PRIVATE HOSPITALS?

☐ Public only

☐ Private only

☐ both

7a. IN GENERAL, DO YOU THINK THAT PUBLIC HOSPITALS PROVIDE BETTER CARE THAN PRIVATE HOSPITALS, PRIVATE HOSPITALS PROVIDE BETTER CARE THAN PUBLIC, THERE IS NO DIFFERENCE, OR THAT IT DEPENDS?

☐ Private better than public

☐ Public better than private

☐ no difference

☐ it depends

7b. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8a. IF YOU DID NOT HAVE MEDICAL INSURANCE AND NEEDED TO GO TO HOSPITAL, WOULD YOU GO TO A PUBLIC HOSPITAL OR A PRIVATE HOSPITAL OR WOULD IT DEPEND?

☐ Public

☐ Private

☐ it would depend

8b. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. WOULD DOING ANY OF THE FOLLOWING THINGS MAKE ANY DIFFERENCE TO THE SERVICE YOU GET FROM PUBLIC HOSPITALS? COULD YOU TELL US IF YOU THINK IT WOULD MAKE A GREAT DEAL OF DIFFERENCE, SOME DIFFERENCE, NOT MUCH DIFFERENCE, NO DIFFERENCE AT ALL?

9a. COMPLAINING TO THE HOSPITAL SUPERINTENDENT?

- ☐ great deal of difference  
☐ some difference  
☐ not much difference  
☐ no difference at all

9b. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_

9c. COMPLAINING TO THE HOSPITAL BOARD?

- ☐ great deal of difference  
☐ some difference  
☐ not much difference  
☐ no difference at all

9d. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_

9e. COMPLAINING TO YOUR FAMILY DOCTOR?

- ☐ great deal of difference  
☐ some difference  
☐ not much difference  
☐ no difference at all

9f. WHY IS THAT? \_\_\_\_\_  
\_\_\_\_\_

9g. COMPLAINING TO THE OMBUDSMAN?

- ☐ great deal of difference  
☐ some difference  
☐ not much difference  
☐ no difference at all

9h. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

9i. WORKING THROUGH AN ORGANIZATION (e.g. CHURCHES, UNIONS, PLUNKET ETC TO IMPROVE HOSPITAL SERVICES?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9j. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

9k. WORKING THROUGH A POLITICAL PARTY TO IMPROVE HOSPITAL SERVICES?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9l. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

9m. DEMONSTRATIONS, STRIKES OR OTHER KINDS OF DIRECT ACTION?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9n. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

9o. COMPLAINING TO THE HEALTH DEPARTMENT?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9p. WHY IS THAT? \_\_\_\_\_

9q. COMPLAINING TO YOUR M.P.?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9r. WHY IS THAT? \_\_\_\_\_

9s. COMPLAINING TO A CABINET MINISTER OR PRIME MINISTER?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9t. WHY IS THAT? \_\_\_\_\_

9u. WRITING TO THE NEWSPAPERS?

☐ great deal of difference

☐ some difference

☐ not much difference

☐ no difference at all

9v. WHY IS THAT? \_\_\_\_\_

10. PEOPLE OVERSEAS PAY CONSIDERABLY MORE FOR THEIR MEDICAL INSURANCE THAN PEOPLE IN NEW ZEALAND. IMAGINE THAT AN OVERSEAS COMPANY, CHARGING OVERSEAS SIZED PREMIUMS CAME TO DOMINATE THE NEW ZEALAND MEDICAL INSURANCE MARKET. WOULD YOU CONTINUE TO PAY YOUR PREMIUMS IF THE COST TO YOU INCREASED BY:

10a. UP TO  $\frac{1}{4}$  AS MUCH AGAIN?

☐ yes

☐ no

10b. UP TO  $\frac{1}{2}$  AS MUCH AGAIN?

☐ yes ☐ no

10c. UP TO DOUBLE YOUR PRESENT PREMIUM?

☐ yes ☐ no

11a. SUPPOSE THERE WAS NO WAITING LIST AND THAT THE STANDARD OF MEDICAL CARE AND THE COST WERE THE SAME, WOULD YOU PREFER TO BE IN A PRIVATE HOSPITAL OR IN A PUBLIC HOSPITAL, YOU WOULDN'T MIND, OR IT WOULD DEPEND?

☐ Private

☐ Public

☐ wouldn't mind

☐ it would depend

11b. WHY IS THAT? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. THE FOLLOWING ARE SOME WAYS THAT PEOPLE CAN TRY AND INFLUENCE THINGS IN GENERAL (RATHER THAN JUST HOSPITAL MATTERS). HAVE YOU DONE ANY OF THE FOLLOWING THINGS IN THE LAST 2 OR 3 YEARS?

12a. WRITTEN A LETTER TO A NEWSPAPER OR A MAGAZINE?

☐ yes ☐ no

12b. (IF YES TO 12a.) HOW MANY? \_\_\_\_\_

12c. CONTACTED A LAWYER ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12d. (IF YES TO 12c.) HOW MANY TIMES? \_\_\_\_\_

12e. CONTACTED YOUR M.P. ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12f. (IF YES TO 12e.) HOW MANY TIMES? \_\_\_\_\_

12g. CONTACTED A CABINET MINISTER OR THE PRIME MINISTER ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12h. (IF YES TO 12g.) HOW MANY TIMES? \_\_\_\_\_

12i. CONTACTED THE OMBUDSMAN ABOUT SOMETHING YOU WANTED DONE?

☐ yes ☐ no

12j. (IF YES TO 12i.) HOW MANY TIMES? \_\_\_\_\_

12k. HAVE YOU WORKED THROUGH ANY ORGANISATION (FOR EXAMPLE, A CHURCH GROUP, A UNION, PLUNKET ETC.), TO TRY AND INFLUENCE PUBLIC POLICY IN SOME AREA?

☐ yes ☐ no

12l. (IF YES TO 12k.) CAN YOU PLEASE SPECIFY? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12m. HAVE YOU TAKEN PART IN ANY DIRECT ACTION LIKE PROTESTS OR STRIKES?

☐ yes ☐ no

12n. (IF YES TO 12m.) CAN YOU SPECIFY? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

13. DID YOU VOTE AT THE LAST GENERAL ELECTION?

☐ yes ☐ no

14. DID YOU GO TO ANY CAMPAIGN MEETINGS AT THE LAST GENERAL ELECTION?

☐ yes ☐ no

15. DID YOU VOTE AT THE LAST LOCAL BODY ELECTIONS?

☐ yes ☐ no

16a. ARE YOU A MEMBER OF A POLITICAL PARTY?

☐ yes ☐ no

16b. (IF YES TO 16a.) WOULD YOU DESCRIBE YOURSELF AS A VERY ACTIVE MEMBER, AN ACTIVE MEMBER, A FAIRLY INACTIVE MEMBER OR AN INACTIVE MEMBER?

☐ a very active member

☐ an active member

☐ a fairly inactive member

☐ an inactive member



17a. DO YOU BELONG TO ANY CLUBS OR ORGANISATIONS (FOR EXAMPLE, A TRADE<sup>265</sup> UNION, A CHURCH GROUP, SOCIAL CLUB, P.T.A. ETC.)?

☐

yes

☐

no

17b. (IF YES TO 17a.) CAN YOU PLEASE LIST ALL THOSE THAT YOU BELONG TO AND SAY HOW ACTIVE A MEMBER YOU ARE OF EACH.

---

---

---

---

18. WOULD YOU SAY THAT YOU WERE MORE, LESS, OR AS LIKELY AS OTHERS IN YOUR CIRCLE OF FRIENDS TO BE ASKED YOUR OPINION ABOUT SOCIAL AND POLITICAL ISSUES?

☐

more likely

☐

less likely

☐

as likely

19a. YOUR SEX IS ☐ male ☐ female

19b. WHAT IS YOUR OCCUPATION? (IF YOU WORK FOR AN ORGANIZATION PLEASE SPECIFY ITS TYPE AND YOUR POSITION IN IT.) \_\_\_\_\_

---

19c. AND (IF A MARRIED WOMAN) THE OCCUPATION OF YOUR HUSBAND?

---

19d. WHAT IS YOUR AGE? \_\_\_\_\_ (YEARS)

19e. AT WHAT AGE DID YOU FINISH YOUR FULL-TIME EDUCATION?

\_\_\_\_\_ (YEARS)

19f. DO YOU HAVE ANY FORMAL EDUCATIONAL QUALIFICATIONS? (FOR EXAMPLE, MATRICULATION, A UNIVERSITY DEGREE, AN ACCOUNTANCY QUALIFICATION, A TRADE CERTIFICATE ETC.)

☐

yes

☐

no

19g. (IF YES TO 19f.) WHAT ARE THEY? \_\_\_\_\_

---

20. FINALLY, CAN YOU TELL ME WHETHER YOUR FAMILY INCOME THIS YEAR (BEFORE TAXES) IS:

- ☐ less than \$2,000
- ☐ less than \$3,000 but more than \$2,000
- ☐ less than \$4,000 but more than \$3,000
- ☐ less than \$5,000 but more than \$4,000
- ☐ less than \$6,000 but more than \$5,000
- ☐ less than \$7,000 but more than \$6,000
- ☐ less than \$8,000 but more than \$7,000
- ☐ less than \$9,000 but more than \$8,000
- ☐ less than \$10,000 but more than \$9,000
- ☐ less than \$11,000 but more than \$10,000
- ☐ less than \$12,000 but more than \$11,000
- ☐ more than \$12,000

PLEASE CHECK BACK TO MAKE SURE THAT YOU HAVE ANSWERED ALL APPLICABLE QUESTIONS. IF YOU HAVE ANY FURTHER COMMENTS THAT YOU WOULD LIKE TO MAKE ABOUT EITHER OUR MEDICAL CARE SYSTEM OR THE QUESTIONNAIRE, PLEASE WRITE THEM IN THE SPACE BELOW. THANK YOU FOR YOUR HELP.

---

---

---

---

## INTERVIEWING.

1) The worth and usefulness of the whole study is crucially dependent on your skill and energy in interviewing. How good a job you do will depend on how much you care and how well you can establish rapport with those you interview, neither of which I can much influence. Interviewing is largely intangibles (personality, manner etc) plus commonsense. Some of that common sense is the following:

2) Being a good interviewer essentially involves being a good listener. You will undoubtedly be treated to a variety of tales which may or may not be interesting and/or relevant. As far as possible let people talk, but where necessary steer them back to, and try to get them to answer, the questions

3) Beware of interviewer effects: raised eyebrows and rising intonation, putting words into peoples mouths etc. Remember that your task is to find out as much as possible about the respondent's view of the world.

A special problem arises when you are asked what you think by the respondent. In general be as non-specific and non-committal as possible. If pressed explain that the purpose of the interview is to find out what the respondent thinks and that your opinions are irrelevant for this reason.

4) As far as possible record the respondent's replies in his own words.

5) Record answers as fully as possible (although some things may be clearly not relevant and can be left out). Probe to clear up ambiguities (e.g. occupation is Assistant Manager, ask of what etc.), and to find out what people have in mind (e.g. the respondent says that "criticism" will improve hospital services. Probe to find out criticism by whom, of what, directed through what channels, to whom etc.). Here your skill and sympathy as interviewers are crucial.

6) Bring the interview in to me as soon as possible (at the latest within 48 hours) so that we can go over it while the situation is still fresh in your mind.

Some questions that People may ask.

1) Why me, how was I chosen etc. Explain that their name was drawn by chance (every 14th name etc.). If they want to know the list their names were drawn from explain that it was (the waiting list at the Public Hospital/Southern Cross files).

2) Who will see it, is it confidential etc. Explain that the interview is confidential and that each person's replies will be mixed together with all other replies so that it is impossible to find out what any one person answered.

3) What's it for etc. Explain that we want to find out what those who use hospital services think of them, so that their point of view can be taken into account in future planning.

4) Does this have anything to do with the hospital? Emphatically NO.

## AT THE DOOR.

1. Ask for the respondent. If he is out find out when he will be back and arrange to interview him at that time (if possible). If the respondent has moved try and find out his new address and interview him there. If you can't discover his new address, or if he will be away until after August 10, or if he is in hospital, or if his new address is out of town or a long distance from your area, contact me (65819, ext. 617) as soon as possible.  
If the person who answers the door is not the respondent and asks why you want the respondent say:  
"My name is.....I'm from the Department of Sociology at the University of Canterbury and I'm interviewing people to find out what they think about our medical care system."
2. Having obtained the respondent say:  
"My name is..... I'm from the Department of Sociology at the University of Canterbury. You'll remember that we wrote you a letter a few days ago. We're trying to find out what people think of our medical care system and we'd like your help. Can I interview you: the interview is completely confidential?"
3. If respondent says yes, ask:  
"Are you on a hospital waiting list?"/"Do you have medical insurance?"  
  
If the respondent says yes, proceed with interview. If respondent says no, then for waiting list ask,  
"Have you been on a waiting list recently"  
  
If the respondent says yes proceed with interview (modifying the questions where necessary to make sense.)  
If the respondent still says no or if he does not have medical insurance, say "I'm sorry for troubling you. In this set of interviews we're only interviewing people on the waiting list/with medical insurance."
4. If respondent says no to your interview request say:  
"We need the opinions of as many people as possible. Are you sure you can't help?"  
  
If the answer is still no, then on the interview schedule record everything you can about the person and his dwelling and anything else that may help identify the people who are not completing interviews.
5. When interview is completed and before you leave the house, quickly check that all applicable questions have been answered and that it is clear what the responses mean.  
This is most important.

APPENDIX 3: LETTERS SENT TO PARLIAMENTARIANS AND HOSPITAL  
BOARD MEMBERS.

29 August 1973

Dear ,[/hospital board member/]

I am currently doing some research on how North Canterbury people evaluate our hospital services. I would be most grateful if (in your capacity as a hospital board member) you could answer the following questions for me.

1. How often, if at all, are you approached as a Hospital Board member by people with complaints about hospital services?  
(Once a week, once a month etc.).
2. To what kinds of things are the complaints related?  
(In particular how many are about bad service within the hospital and how many relate to the difficulty of getting into hospital, getting access to appropriate hospital facilities etc.).
3. How often do such complaints come before the Board as a whole (at most Board meetings, at no Board meetings etc.).

The negative line of questioning by no means implies a negative evaluation of our public hospital services. I am interested simply in finding out if those people (if there are any) who are dissatisfied with the provision of hospital care get around to actually venting their dissatisfaction in any quarter.

I will be most grateful for any help that you can give me.

Yours sincerely

G.M. Fougere  
Assistant Lecturer  
in Sociology

14 December 1973

Dear ,[/hospital board member/]

Earlier this year I wrote to you explaining that I was doing research on how North Canterbury people evaluated their hospital services and requesting information on how many (if any) complaints you had received as a Hospital Board Member. The replies I have received from Board Members have been most helpful.

In part of my research I am looking at the use people make of private hospitals as an alternative to public hospitals. In this regard I would be most grateful if you could answer the following questions for me (where possible, I would appreciate it if you could give reasons for your answers):

1. Do you think that public and private hospitals together have a vital role to play in providing medical care, or do you think that public hospitals are handicapped in providing medical care by the existence of private hospitals? (or neither of these things?)
2. Would you like to see it made easier, or more difficult (or neither) for people to make use of private hospitals?
3. Are you against or in favour (or neither) of the present rapid growth in the numbers of people with medical insurance?

Any use I make of the information will preserve the complete anonymity of Board Members, being present in the form "7 out of 14 Board Members favour making it easier for people to make use of private hospitals" and so on. As this is the last piece of information I require to write up the research (which includes a survey of almost 300 "consumers" of medical care in the Christchurch area, I would be most grateful if you could reply as soon as possible. Thank you for your time and patience with regard to this letter and the last one. I hope to have a summary of my research findings available for circulation by about the end of February.

Yours sincerely,

G.M. Fougere  
Assistant Lecturer  
in Sociology.

9 August 1973

Dear ,[/member of parliament/]

I am currently doing research aimed at finding out what New Zealanders think of our present system of hospital care. One of my problems is to establish whether or not complaints are being lodged by those who are dissatisfied (if such people exist). Thus I would be most grateful if you could answer the following three questions for me.

1. In the last year about how many (if any) of your constituents have approached you with complaints related to (non-psychiatric) hospital services?
2. How does this number compare with the number of complaints arising out of other areas that you deal with as a local M.P. (for example social security problems etc.).
3. What sort of thing (if any) lead people to complain about hospital service.

I will be most appreciative of any help that you can give me.

Yours sincerely,

G.M. Fougere  
Assistant Lecturer  
In Sociology



APPENDIX 4: WHY PEOPLE TAKE OUT MEDICAL INSURANCE: THE  
SOUTHERN CROSS EVIDENCE CONSIDERED.

My finding that; "the major source of their [those who take out medical insurance] dissatisfaction is the supply rather than the standard of public sector care..." appears inconsistent with survey evidence cited by Southern Cross to refute,

the regular suggestion that it is only some inability on the part of the public hospital system to cope that allows private hospitals to have so many patients. In other words, people are supposedly forced to enter private hospitals because they do not want to become a statistic on a public hospital waiting list, or they do so because they wish to "jump the queue!"

The survey was of a "random sample of 200 surgical patients at five Auckland private hospitals". Those interviewed were "offered the choice of the above five alternatives and were asked to state which one most accurately described the reason for them entering a private hospital". The results were as follows:

	No.	%
a. Wished to be operated upon by surgeon of own choice	63	31.5
b. Preferred Private Hospital	47	23.5
c. Could not wait for a public hospital bed	43	21.5
d. Covered by Health Insurance	36	18.0
e. Other reasons	11	5.5
	<hr/> 200	<hr/> 100.0

[Thus] the majority of patients either wanted their own choice of surgeon, or simply preferred private treatment. But only about one patient in five sought private hospital treatment because of the public waiting list.

There are a number of possible reasons for the discrepancy between the Southern Cross finding and my own. The first, and most obvious, is that the populations on which the findings are based are different. My finding refers to the reasons why people take out medical insurance and is based on a random sample of Southern Cross policy holders in the Christchurch urban area; while Southern Cross's findings refer to why people are in a private rather than a public hospital and is based on a random sample of Auckland private hospital patients.<sup>2</sup> Thus, the two populations surveyed are overlapping, rather than co-extensive; the difference in the findings may simply reflect real differences between two populations.

Let us assume that this is not the case; that for all practical purposes the two populations surveyed can be treated as identical. Now a second possibility appears: that the results are inconsistent because one, or both samples are biased. In the case of the medical insurance sample this means either; (or both);

1. That the sample drawn is atypical of Southern Cross members in Christchurch and/or
2. That Christchurch members of Southern Cross are atypical of national membership.

The first source of bias is guarded against by the sampling procedure used, but, other than the belief of the Southern Cross general manager that Christchurch is not atypical in its membership, there is no check on the second.

Assuming that Southern Cross's sample is equally unaffected by bias and that the two samples are drawn from the same population a final possible solution (barring simple misreporting) to the discrepancy occurs: that the form of the question asked has significantly biased the responses.

Although Southern Cross's question is open to severe criticism on a number of counts only two crucial objections will be raised here. First, even although respondents may have a number of reasons for choosing a private rather than a public hospital, the form of the question allows them to nominate only one. In contrast the open ended question I used (on the advantages of medical insurance) allows the respondent to give as many different kinds of reasons as he wishes, while the closed question I used does not force him to choose between the reasons given.

Second, the distribution of responses in Southern Cross's question is crucially affected by the number of choices offered. Thus if respondents were offered only a choice between a. and c. the distribution of answers would be very likely quite different. Neither of my questions have this feature.

Finally, considering the Southern Cross questions and my own together, it is clear that the form of any question, no matter how well constructed, has some impact on the kind of responses given to it. By using two questions of different kinds, as I have done, the researcher has a useful check on the validity and reliability of the information he has obtained. When the findings of two different kinds of question are congruent, as they are in reporting the overwhelming importance of inadequate supply as a factor in taking out medical insurance, the researcher can have a great deal of confidence in his findings. I have a great deal of confidence in my finding on the crucial importance of not being able to get into a public hospital, in the decision to take out medical insurance.

## NOTES.

<sup>1</sup>All information on the Southern Cross survey is from Southern Cross Medical Society, "Submissions".

<sup>2</sup>In their submission Southern Cross note,

recent surveys of 650 surgical cases at 5 of Auckland's private hospitals revealed that 220 (or 33.8% were covered by voluntary health insurance and a sampling of these figures show that almost 80% were Southern Cross members.

## LIST OF REFERENCES CITED.

Books

Almond, Gabriel and Sydney Verba, The Civic Culture (Princeton: Princeton University Press, 1963).

Altshuler, A.A. Community Control (New York: Pegasus, 1970).

Bassett, M.E.R. Confrontation '51: The 1951 Waterfront Dispute (Wellington: Reed, 1972).

Berelson, Bernard Content Analysis in Communication Research (New York: The Free Press, 1952).

Blalock, Hubert M. and Ann B. Blalock (ed) Methodology in Social Research (New York: McGraw-Hill, 1968).

Buchanan, James M. and Robert D. Tollison (eds) Theory of Public Choice (Ann Arbor: The University of Michigan Press, 1972).

Cooper, Michael H. and Anthony J. Culyer The Price of Blood Hobart Paper no. 41 (London: The Institute of Economic Affairs, 1968).

Dahl, Robert A. Who Governs (New Haven: Yale University Press, 1961).

Dodge, J.S. (ed) The Organisation and Evaluation of Medical Care (Dunedin: Dept. of Preventative and Social Medicine, University of Otago Medical School, 1970).

Downs, Anthony An Economic Theory of Democracy (New York: Harper & Row, 1957).

Downs, Anthony Urban Problems and Prospects Markham Series in Public Policy Analysis (Chicago: Markham Publishing Company, 1970).

Duff, Raymond S. and August B. Hollingstead Sickness and Society (New York: Harper & Row, 1968).

Friedman, Milton Capitalism and Freedom (Chicago: The University of Chicago Press, 1962).

Friedman, Milton Essays in Positive Economics (Chicago: University of Chicago Press, 1953).

Galtung, Johan Theory and Methods of Social Research Revised ed., (New York: Columbia University Press, 1969).

Geiringer, Erich If Doctors Grew on Trees... (Dunedin: John McIndoe Limited, 1969).

Hirschman, Albert O. Exit, Voice, and Loyalty: Responses to Decline in Firms, Organisations and States (Cambridge,

Mass: Harvard University Press, 1970).

Latimer, R.J. (ed) Health Administration in New Zealand (Wellington: New Zealand Institute of Public Administration, 1969).

Lees, D.S. Health Through Choice Hobart Paper no. 14 (London: The Institute of Economic Affairs, 1961).

Lovell-Smith, J. The New Zealand Doctor and the Welfare State (Auckland: Blackwood and Janet Paul, 1966).

Marmor, Theodore R. with Jan S. Marmor The Politics of Medicare Library of Social Policy and Administration (London: Routledge & Kegan Paul, 1970).

Mechanic, David Public Expectations and Health Care (New York: Wiley Interscience, 1972).

Milbrath, Lester Political Participation (Chicago: Rand McNally, 1963).

Moser, C.A. and G. Kalton Survey Methods in Social Investigation 2nd ed. (London: Heinemann Educational Books Ltd, 1971).

Olson, Jr. Mancur The Logic of Collective Action (Cambridge Mass: Harvard University Press, 1965).

Pascal, A.H. (ed) Thinking About Cities (Belmont, Calif: Dickenson, 1970).

Schattschneider, E.E. The Semi-Sovereign People (New York: Holt, Rinehart and Winston, 1960).

Susser, M.W. and W. Watson (eds) Sociology in Medicine 2nd ed. (London: Oxford University Press, 1971).

Sutch, W.B. The Responsible Society In New Zealand (Christchurch: Whitcombe and Tombs Ltd, 1971).

Titmuss, R.M. Commitment to Welfare (London: George Allen & Unwin Ltd, (1968).

Titmuss, R.M. The Gift Relationship (London: George Allen & Unwin Ltd, 1970).

Webb, Eugene J. et al Unobtrusive Measures: Nonreactive Research in the Social Sciences (Chicago: Rand McNally & Company, 1966).

#### Journal Articles

Barry, Brian "Review Article: 'Exit, Voice, and Loyalty'" British Journal of Political Science 4, (1974), 79-107.

Fougere, G.M. and J.M. Orbell "A Proposal to Establish a Centre for the Study of New Zealand Society" (Forthcoming, Australia and New Zealand Journal of Sociology, October 1974).

- Hardin, Garret "The Tragedy of the Commons" Science 162 (1968), pp.1243-1248.
- Hart, J.J. "The Inverse Care Law" The Lancet (1971), pp.405-412.
- La Piere, R.T. "Attitudes vs. Actions" Social Forces 14 (1934), pp.230-237.
- Newhouse, Joseph P. and Vincent Taylor "The Subsidy Problem in Hospital Insurance: A Proposal" Journal of Business 43 (1970), pp.452-456.
- Orbell, John M. and Geoffrey Fougere "Intra-Party Conflict and the Decay of Ideology" The Journal of Politics 35 (1973), pp.439-458.
- Orbell, John M. and Toru Uno "A Theory of Neighbourhood Problem Solving: Political Action vs. Residential Mobility" American Political Science Review 66 (1972), pp.471-489.
- Salmond, G.C. and E.M. O'Connor "General Surgical Waiting Lists and the Management of Varicose Veins" New Zealand Medical Journal 78 (1973), pp.394-400.
- Scotton, R.B. "Membership of Voluntary Health Insurance" Economic Record 45 (1969), pp.69-83.
- Thompson, A.N. and R.B. Elliot "Factors in Hospital Usage and Morbidity in the Auckland Area" New Zealand Medical Journal 75 (1972).
- Young, Dennis R. "Institutional Change and the Delivery of Urban Public Services" Policy Sciences 2 (1971), pp.425-438.
- Werry, J.S. "Time for a Change?" New Zealand Medical Journal October 10, (1973), pp.303-306.

#### Official Publications

- Department of Health Hospital Statistics of New Zealand Year Ended 31 March, 1972 (Wellington: Department of Health, 1972).
- Department of Health The Public Health, Report of the Department of Health for the Year ended 31 March, 1973 (Wellington: Government Printer, 1973).
- Department of Health A Review of Hospital and Related Services in New Zealand (Wellington: Government Printer, 1969).
- Joint Committee on Medical Graduate Needs Report on Medical Graduate Needs in New Zealand for the Years 1968-2000 (Wellington: Department of Health, 1970).
- New Zealand Consultive Committee on Hospital Reform. Report (Wellington: Government Printer, 1953).

The New Zealand Gazette, 2 March 1972.

Parliamentary Debates, First Session Thirty-seventh Parliament, 1973, No. 2.

Private Hospitals in New Zealand Board of Health Report Series: No. 20 (Wellington: Board of Health, 1974).

The Royal Commission on Social Security in New Zealand Social Security in New Zealand (Wellington: Government Printer, 1972).

Thompson, A.W.S. Where Should I Practice? (Wellington: Department of Health, 1973).

#### Newspapers and Magazines

Christchurch Star, 24 October, 1973.

Christchurch Star, 27 April, 1974.

New Zealand Herald, 14 December, 1973.

The New Zealand Woman's Weekly, 19 November, 1973.

Otago Daily Times, 26 April, 1973.

The Press, 21, 27 April; 13 September; 21, 25 October; 16 November; 1973.

The Press, 26 January; 28 February; 8, 27, 30 March; 3, 13 April; 1974.

#### Other

Consumer Review, 1 (1974).

Dawes, Robyn M. "The Commons Dilemma Game: An N-Person Mixed Motive Game with a Dominating Strategy for Defection", Ori Research Bulletin, 13 (1973).

Department of Health "Projection of Medical Manpower Needs to the Year 2,000" (mimeo, 1973).

King, Hon. N.J. "Speech at the Opening of the Lister Hospital Extensions Auckland, Saturday October 13, 1973". (mimeo).

Medical Association of New Zealand "Submissions to the Board of Health Committee on Private Hospitals" (mimeo, 1972).

Mitchell, William C. "Theories of Governmental Choice: Downsian and Post Downsian Contributions" (paper prepared for delivery at the 1971 Annual Meeting of the American Political Science Association, Chicago, Illinois, September 7-11, 1971).

The New Zealand Labour Party "Report of the 57th Annual Conference", (mimeo, 1973).



The New Zealand Labour Party 1972 Election Manifesto  
(Wellington: Standard Press, 1972).

Public Service Association Inc. P.S.A. Newsletter, 19 (1973).

Salmond, G.C. "A Comparative Study of Disease Specific  
Length of Stay in New Zealand Hospitals" The Department  
of Health, Occasional Paper, No. 1 (Wellington: The  
Department of Health, 1972, mimeo).

Southern Cross Medical Care Society "Submissions to the  
Board of Health Inquiry into Private Hospitals" 1972 (mimeo).

Thompson, Richard Planners Motorways and People (Christchurch:  
Department of Psychology and Sociology, 1973).

Tizard, Hon. R.J. "Press Statement by the Minister of Health  
Hon. R.J. Tizard on Report on Private Hospitals. 26/3/74"  
(mimeo)

Tizard, Hon. R.J. "Address to the Medical Association of  
New Zealand" (mimeo, 1973).